

The Mobile Integrated Response System (MIRS) Program Evaluation:

Gauging the Program's Impact on Indiana's Opioid Response



THIRD HORIZON
STRATEGIES



**Division of Mental
Health and Addiction**

This report was prepared for the Indiana Family and Social Services Administration – Division of Mental Health & Addiction, (DMHA) under contract. The views, opinions, and content of this publication are those of the authors and do not necessarily reflect the views, opinions, or policies of DMHA.

EXECUTIVE SUMMARY

Behavioral health needs have increased across the nation and in Indiana. According to [the Kaiser Family Foundation](#), from 2011 to 2021, the [age-adjusted death rate due to opioid overdose](#) increased from 5.6 per 100,000 to 34.2 per 100,000 in Indiana. Provisional data from [the Indiana Department of Health](#) show that in 2022, 2,250 deaths from overdoses (of any drug) and 17,445 emergency department visits (of any drug)

added. The program uses a combination of the Trauma-Informed – Recovery Oriented System of Care (TI-ROSC) and community-based mobile response teams to close critical system gaps in local regions. MIRS sites partner with various health, criminal justice, and social systems to provide a multi-faceted, integrated approach for those experiencing OUD and stimulant use disorders. The core function of a MIRS team is to provide a warm handoff for the individual to the next appropriate intervention and step towards recovery. In 2023, a total of 11 MIRS sites operated in over 30 counties, both rural and urban, across Indiana.

In the fall of 2022, Third Horizon Strategies (THS) was competitively selected by DMHA to 1) evaluate the MIRS program statewide for service delivery, quality, capacity, outcomes, and sustainability; 2) visit each of the individual 11 MIRS sites to identify specific practice strengths and challenges; and 3) provide DMHA with recommendations for the MIRS program sustainability long-term.

THS conducted its work in two phases: 1) discovery and design and 2) implementing learnings and evaluation. During the first

stage, THS engaged with DMHA to finalize the impact evaluation approach. The team then implemented a seven-month formal evaluation that included:

- reviewing each MIRS site grant documentation and history;
- compiling existing and available data sets focused on the impact of opioid and stimulant use disorder in Indiana and analyzing the state's reporting data from the MIRS sites;
- developing a formal assessment tool and protocol for each of the 11 MIRS site visits;
- conducting 11 site visits of each MIRS site, including key informant interviews with community collaborators;



Beacon Health with Oaklawn Psychiatric Center

in Indiana. According to the Centers for Disease Control and Prevention (CDC), as of 2021, Indiana had the country's 10th highest drug overdose mortality rate at 43.0/100,000.

As a result of the devastating human and economic toll of the opioid crisis, the Indiana Family and Social Services Administration – Division of Mental Health & Addiction (DMHA) developed the Mobile Integrated Response System (MIRS) using federal funding provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), State Opioid Response (SOR) grant. The MIRS program was designed to serve people with opioid use disorder (OUD) starting in 2019, and in 2020, stimulant use disorders were

- collecting and reviewing quantitative data on individuals participating in the MIRS program at the various sites, including all Government Performance and Results Act (GPRA) data submitted through SAMHSA's Performance Accountability and Reporting System (SPARS) through February 2022, and;
- performing comparative analysis across all levels of operation of each MIRS program.

THS synthesized its findings from the site visits and identified several consistent themes across the 11 sites:

- limited transportation options existed, whether MIRS sites were in urban or rural settings;
- a significant housing shortage exists across the state, often exacerbated by the unique needs of the recovery population [such as justice-involved, health conditions, or use of medications for opioid use disorders (MOUD)];
- MIRS personnel often acted as navigators for recovering individuals. This could include case management, navigation of health care systems, justice-system support, or accessing public benefits;
- MIRS sites help reduce stigma and increase adoption of medications for opioid use disorder (MOUD);
- MIRS has significantly impacted community attitudes towards SUD and recovery in every community they have served;
- Indiana's Division of Mental Health and Addictions (DMHA) is a crucial partner to all sites, providing needed support and assistance that helps make the MIRS program successful and;
- the limited nature of grant funding unintentionally creates a two-tiered system where those identifying as having an opioid or stimulant use disorder have better access to services than those with an alcohol use or other substance use disorder.



Davieess Team

Based on its analysis, THS formulated five recommendations to maintain and enhance the MIRS program:

Recommendation #1 – Identify and secure additional funding

Finding and maintaining consistent and additional funding pathways for the MIRS program is vital to ensure its long-term viability, sustainability, and growth. THS recommends that the state explore new approaches to funding the MIRS program by conducting a detailed fiscal and regulatory analysis, including the feasibility of using other state, Medicaid, public health, and justice-related funds to support the cross-sector work.

Recommendation #2 – Set a minimum GPRA data submission threshold

If SOR continues as a primary funding source for the MIRS program, the participating sites will be required to administer GPRA assessments. To maintain accountability and service quality, THS recommends that DMHA requires a minimum GPRA data submission from MIRS sites moving forward.

Recommendation #3 – Develop consistent Key Performance Indicators (KPIs)

Given the incongruity of the GPRA tool with the work of the MIRS team, DMHA should develop a separate set of consistent Key Performance Indicators (KPIs) not reliant upon self-report that each site, in collaboration with the state, is required to track.



Eskenazi Health Team

Recommendation #4 – Work with Integrated Re-entry and Correctional Support (IRACS)

THS urges the State of Indiana to consider extending the program’s reach to work with all Integrated Re-entry and Correctional Support (IRACS) sites. Collaborating with these sites can significantly extend MIRS reach and support of justice-involved individuals, thereby reducing costs and improving outcomes.

Recommendation #5 – Implement support networks for MIRS site staff

The impact of vicarious trauma on staff at the MIRS sites can be profound and far-reaching. The staff, including peer recovery coaches, often form strong bonds with those they assist. Unfortunately, the nature of their work means they are not immune to experiencing loss themselves. MIRS-

funded organizations must implement support systems for staff that prioritize their well-being, providing access to counseling, peer support networks, and opportunities for self-care and reflection. Such measures can help these dedicated professionals navigate their emotions while continuing to offer valuable support to those on their recovery journeys.

Maintaining and expanding the MIRS program can profoundly benefit Indiana’s communities, behavioral health workforce, and individuals in recovery. These systems can make a significant positive impact by facilitating timely access to

care, fostering collaboration among various stakeholders, and providing personalized support. Embracing and investing in such initiatives is a critical step towards building more resilient, empathetic, and healthier societies where those experiencing SUDs are met with understanding, hope, and the support they need to reclaim their lives.

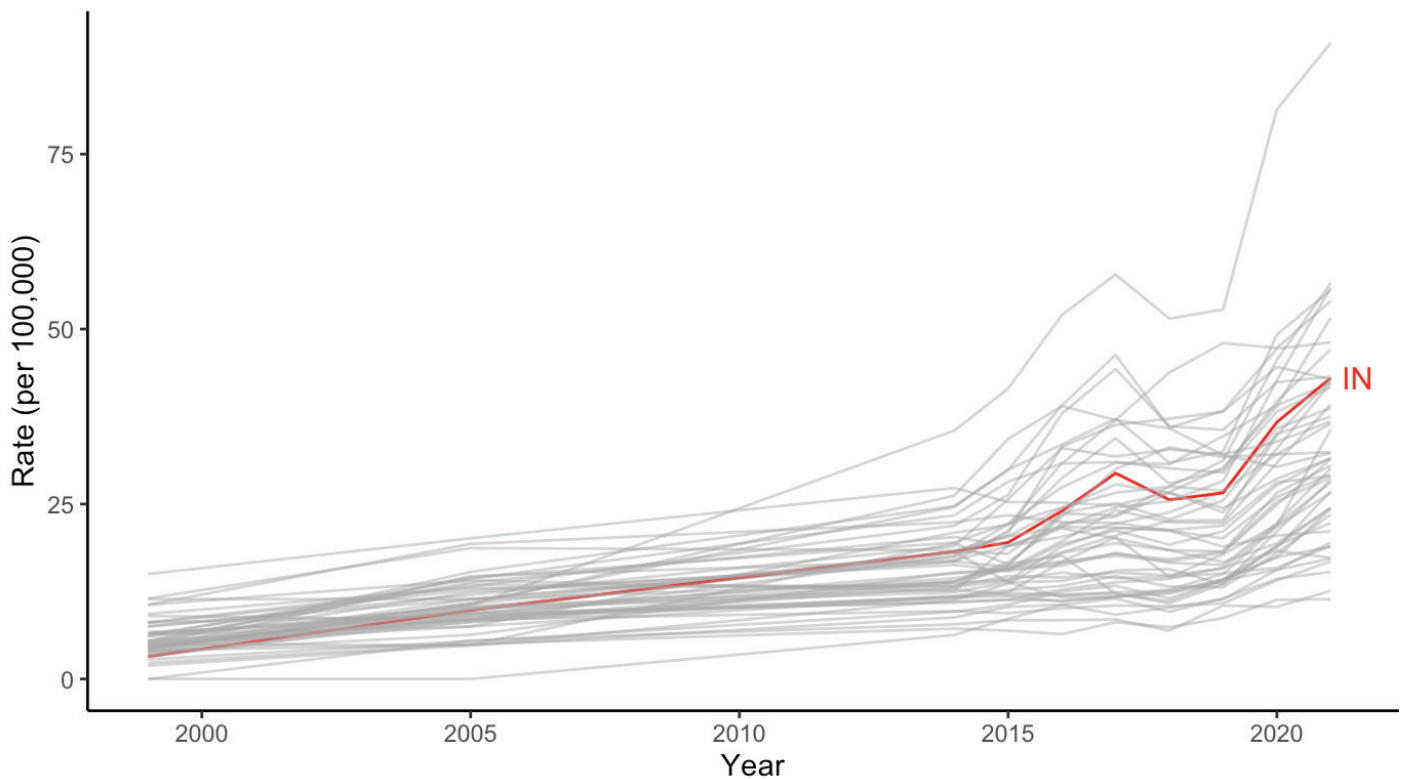
BACKGROUND AND PURPOSE

The opioid crisis has devastated the nation including the State of Indiana in recent decades. According to [the Kaiser Family Foundation](#), from 2011 to 2021, the [age-adjusted death rate due to opioid overdose](#) increased from 5.6 per 100,000 to 34.2 per 100,000 in Indiana. Provisional data from [the Indiana Department of Health](#) show that in 2022, there were 2,250 deaths from overdoses (of any drug) and 17,445 emergency department visits (of any drug) in Indiana. According to the Centers for Disease Control and Prevention (CDC), as of 2021, Indiana had the 10th highest drug overdose mortality rate in the country at 43.0/100,000 (See Figure 1).

In 2018 [Indiana University published a study](#) that found that from 2003 to 2018, the opioid epidemic had cost the state a total of \$43.3 billion. The report also predicted that state product losses from the accrual of deaths in Indiana would likely exceed \$1.25 billion in 2018, and another \$1.75 billion would be lost due to individuals who are underemployed as a result of their untreated substance use disorder.

In February 2022, [Forbes](#) published a national study from [the Society of Actuaries \(SOA\)](#) that estimated the opioid epidemic costs the U.S. \$1.3 trillion annually in specific social domains including, lost productivity, criminal justice involvement, and health care costs. It is important

Figure 1. Drug Overdose Mortality Rate by State



Source: <http://wonder.cdc.gov>

to recognize the broad economic impact opioid use disorder (OUD) has across sectors in society (see Figure 2) in order to design novel solutions and responses.

Figure 2. Per Person Economic Impact Estimate of OUD

LIVING WITH OPIOID USE DISORDER	
Reduced quality of life:	\$183,200
Lost productivity:	\$14,700
Healthcare costs:	\$14,700
Criminal justice:	\$7,000
Substance use treatment:	\$1,600
Total cost:	\$221,200

As a result of the devastating human and economic toll of the opioid crisis, the Indiana Family and Social Services Administration - Division of Mental Health & Addiction (DMHA) developed the Mobile Integrated Response System (MIRS) using federal funding provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), State Opioid Response (SOR) grant. The MIRS program was designed to serve people with OUD starting in 2019, and in 2020 stimulant use disorders were added. The program uses a combination of the Trauma-Informed - Recovery Oriented System of Care (TI-ROSC) and community-based mobile response teams intended to close critical system gaps in local regions. MIRS sites partner with various health, criminal justice, and social systems to provide a multi-faceted, integrated approach for those experiencing OUD and stimulant use disorders. The core function of a MIRS team is designed to provide a warm handoff for the individual to the next appropriate intervention and step towards recovery. In 2023, a total of 11 MIRS sites operated in over 30 counties, both rural and urban, across Indiana (Figure 3).

The MIRS teams are comprised of peer recovery coaches and clinicians who provide outreach, treatment, recovery, and harm reduction services, with the option to add prescribers and first responders to the team as appropriate. All the MIRS teams work with community stakeholders to ensure that services provided along the full continuum of care for opioid and stimulant use disorders are accessible and adequately serve people within their region. While the overall objective across all MIRS sites is the same, each team has adapted a service delivery approach best suited to meet the needs of its local community (Figure 2).

Figure 3: Indiana State-Funded MIRS Sites and Program Inception Year

SITE	INCEPTION YEAR
Beacon Health Group with Oaklawn Psychiatric Center	2019
Choices Coordinated Care Solutions	2020
Daviess Community Hospital	2022
Health & Hospital Corporation with Eskenazi Health	2019
Good Samaritan Hospital	2021
HealthLinc	2019
Integrative Wellness	2019
One Community One Family	2019
The Lutheran Foundation	2019
Turning Point SOC	2021
Valley Oaks with Phoenix Paramedics	2019

In the fall of 2022, Third Horizon Strategies (THS) was competitively selected by DMHA to 1) evaluate the MIRS program statewide for service delivery, quality, capacity, outcomes, and sustainability; 2) visit each of the individual 11 MIRS sites to identify specific practice strengths and challenges; and 3) provide DMHA with recommendations for the MIRS program sustainability long-term. This report is the culmination of these areas of initial work that occurred from December 2022 to September 2023.

Figure 4: MIRS Teams Provide an Anchor to Various Disparate Systems and Services



METHODOLOGY

THS conducted its work in two distinct phases: 1) discovery and design and 2) implementing learnings and evaluation. THS engaged with DMHA to finalize the evaluation approach. The team then implemented a seven-month formal independent evaluation that included:

- reviewing each MIRS site grant documentation and history;
- compiling existing and available data sets focused on the impact of opioid and stimulant use disorder in Indiana and analyzing the state’s reporting data from the MIRS sites;
- developing a formal assessment tool and protocol for each of the 11 MIRS site visits;
- conducting 11 site visits of each MIRS site, including key informant interviews with community collaborators;
- collecting and reviewing quantitative data on individuals participating at the various MIRS sites, including all Government Performance and Results Act (GPRA) data submitted through SAMHSA’s Performance Accountability and Reporting System (SPARS) through February 2022, and;
- performing comparative analysis across all levels of operation of each MIRS program.

Site Visits

THS met with DMHA to define the overall project’s critical evaluation questions and approach. The THS team then developed the first draft of the site visit agenda, interview guide, and site visit schedule. The team shared the draft agenda and guide with DMHA for review and feedback. After incorporating feedback from the DMHA team, THS shared the agenda and interview guide with each site and scheduled one-day site visits to each of the 11 MIRS sites. The site visits were scheduled for the months of February, March, and April 2023.

Ahead of their respective site visit, each MIRS team was given the flexibility to adapt the agenda to their prevailing circumstances, provided they would address all the questions contained in the interview guide being used statewide. Across all teams, two approaches were adopted in executing the agenda: roundtable discussions and one-on-one interviews

Each site visit followed this basic structure:

1. **Meeting 1:** THS met with the MIRS team to discuss their approach to implementation (within their focus communities) and obtain responses to questions on the structure, staffing, and other core components of their version of the MIRS program.
2. **Meeting 2:** THS met with the data sub-team or identified staff member to discuss their approach to data collection, organization, analysis, and use, focusing on the GPRA data collection tool required by the federally SAMHSA-funded SOR program.
3. **Meeting 3:** THS met with community partners to discuss the impact and contributions of the MIRS program to the community and the population they serve and to understand the role the MIRS has played in the broader recovery community and infrastructure. THS toured the MIRS team offices, partner facilities, or community resources that regularly work with the MIRS team.
4. **Meeting 4:** If needed, THS reconvened with the MIRS team to address any additional issues not discussed earlier, including recommendations and feedback for DMHA to strengthen the program.

At the beginning of each meeting, THS provided an overview of the questions in the interview guide, and the MIRS team would respond to the questions during the conversations that followed while multiple THS team members took notes. At the end of the meeting, the THS team repeated any questions the MIRS team did not cover during the discussion.

The MIRS teams used different tools to provide information and context to the THS team, including PowerPoint slides, printed documents, and whiteboard notes. Regardless of the tools, all

teams engaged in robust conversations with the THS team and provided most of the responses to the interview guide questions during these conversations.

After conducting the site visits, the THS team compiled notes and synthesized common themes and recurring issues raised by the different MIRS sites.

Data analysis

THS received two files of statewide GPRA data that was exported from SAMHSA's Performance Accountability and Reporting System (SPARS). The first file spanned from April 2019 through August 2021. The second file contained data from the beginning of September 2021 through December 2022. Data for 2022 was incomplete as organizations were in the process of transitioning to new SOR 3 reporting requirements. THS would not have the opportunity to evaluate complete data for 2022 during the evaluation period.

THS analyzed the data in R, an open-source language and environment for statistical computing and graphics. The two data sets were



LIFT Team (Good Samaritan)

imported into R and bound together. Data were then grouped according to the site by matching Client ID to each site's respective Client ID code(s). Any data without a Client ID code match was filtered out for this analysis, whether reporting cumulative or site-specific outcomes, leaving 5238 observations out of a total of 8465, or 62 percent of the data.

THS began its exploratory data analysis (EDA) with a list of questions related to both utilization and outcomes that the team hoped to answer from the data (see section on GPRA analysis). In exploring these questions, the team performed an analysis of outcomes related to abstinence, employment, housing, criminal justice involvement, self-satisfaction, and social connectedness. Questions were also evaluated for how feasible they were to answer given the data available, taking into account factors like availability of data, missing information, and follow-up rates.

LIMITATIONS

THS' quantitative evaluation is subject to limitations that affect the generalizability and reliability of certain conclusions. First, having incomplete data for 2022 affected the ability to conduct time series analysis or effectively evaluate for follow-ups. The trendline month over month suggests that the later in the year 2022, the more events were missing from the report. This observation aligned with the team's conversations with the MIRS sites about the transition to a new reporting system.

Second, limitations of the GRPA tool also had a significant impact on the data analysis. While the tool serves as a valuable assessment instrument for certain programs, it may not be the most appropriate fit for the nature of services delivered in the context of outreach and engagement, and recovery support. These services often involve

personalized and multifaceted approaches tailored to the individual needs of those in need or seeking help. The standardized and inflexible structure of the GRPA tool can hinder accurate data collection and analysis for the population served by the MIRS teams, potentially overlooking critical elements that contribute to the effectiveness of the services and support provided. As a result, the data provided to THS might not fully capture the complexities and nuances of the program's impact, limiting a comprehensive assessment of its true efficacy.

Third, data collected for this report also relies heavily on self-report measures, which are susceptible to response bias and inaccuracies due to participants' subjective interpretations and recall abilities. Fourth, certain outcome measures can only be understood in the context of what services are provided at a specific site and/or internal procedures for conducting GPRA interviews. The inconsistent data reporting by different sources, particularly GPRA data, introduces variability and potential inconsistencies in our analysis.

Lastly, the use of differing models and methodologies of implementation across different MIRS sites introduces variations in the measurement and analysis process, making it challenging to compare and aggregate the results effectively. These limitations should be taken into consideration when interpreting the results of the data analysis.

OVERVIEW OF MIRS SITE STRUCTURE AND STAFFING

While each MIRS site had a consistent overall program goal, the THS team observed different approaches to program structuring and staffing by the MIRS teams. The different approaches observed are summarized below.

Model 1

The MIRS site is a Certified Community Behavioral Health Clinic (CCBHC), hospital, Federally Qualified Health Center (FQHC), or primary health care provider. This model often meant that the MIRS site ran the program as an add-on to existing mental health or SUD services offered by the provider. Depending on the resources available or the organization's structure, the site either set up a new distinct MIRS team or added the MIRS responsibilities to existing staff. In most cases, the team was comprised of SUD clinicians, therapists, supervisors, nurse practitioners or physicians, and peer recovery coaches. Usually, the peer recovery coaches deployed in this model were explicitly funded by the MIRS grant. Although the peer coaches and staff of these MIRS teams were affiliated with the health care provider that served as the recipient of the MIRS grant, they were not restricted to only providing services to existing clients of the health care program, but many of the individuals served were existing patients.

Model 2

The MIRS site is a behavioral health, addiction treatment, or recovery support services provider. Sites in this category often implemented the

MIRS program as a component of their larger behavioral health or substance use services or as a stand-alone program. These sites usually had teams comprised of peer recovery coaches, supervisors, clinicians, and therapists with multiple responsibilities/functions. The staff of these sites either worked as part of larger community substance use response initiatives, multiorganizational partnership agreements, resources embedded in health care facilities, or a combination of all of these. The peer recovery coaches and their supervisors were usually explicitly funded by the MIRS grant. The staff of the MIRS sites in this category, although affiliated with certain organizations, were largely unrestricted in terms of the clients they could serve. They often had a community focus, could meet clients at a convenient location, and accepted referrals from a variety of sources.

Model 3

The MIRS site is staffed by a coalition of service organizations that have formed to implement the MIRS program, while an independent non-service-providing organization serves as the grant administrator. The coalition is comprised of several organizations, including health care providers, social services organizations, law enforcement, and first responders, who, with funding from the MIRS grant, have included peer support and/or other recovery support services as part of their service offerings. Although each organization within the coalition supports the recovery community in a way that is aligned with its priorities/capabilities, all the organizations work together and refer clients to each other to ensure that every client can access all the services they need for their recovery. The coalition's organizations and their staff are diverse, including clinicians, therapists, medical



personnel, social workers, navigators, etc. Most of the organizations that included system navigation support or peer support as part of their recovery support services explicitly funded this through the MIRS grant. Only one site utilized this model.

Across all the models and staffing structures, the peer recovery coaches were the keystone of every team, with every site emphasizing the value they brought to the project. Figures 5 and 6 below provide an overview of each site.

ROLE AND ENGAGEMENT OF COMMUNITY PARTNERS

The MIRS RFF included language that encouraged sites to work with community partners, including first responders. THS observed that all the MIRS sites had robust community partnerships both within and outside of the recovery community. Most of the partnerships were informal and came from relationships the MIRS team had built within the community. One site, The Lutheran Foundation, has formal contracts/agreements with partners.

Figure 5: Map of Counties Covered by Vendors



Beacon Health Group with Oaklawn Psychiatric Center
St. Joseph, Elkhart, Marshall Counties



HealthLinc
Porter, Starke, LaPorte, Lake Counties



The Lutheran Foundation
Allen County (and surrounding areas)



Turning Point SOC
Howard, Tipton, Madison Counties



Health & Hospital Corporation with Eskenazi Health
Marion County



Integrative Wellness
Boone, Clinton, Montgomery Counties



Valley Oaks with Phoenix Paramedics
Tippecanoe, White, Jasper Counties



Good Samaritan Hospital
Knox, Pike Counties



Davies Community Hospital
Davies County



Choices Coordinated Care Solutions
Wayne, Fayette, Decatur, Switzerland, Jefferson, Franklin, Ripley, Ohio Counties



One Community One Family
Dearborn County (w/Choices)

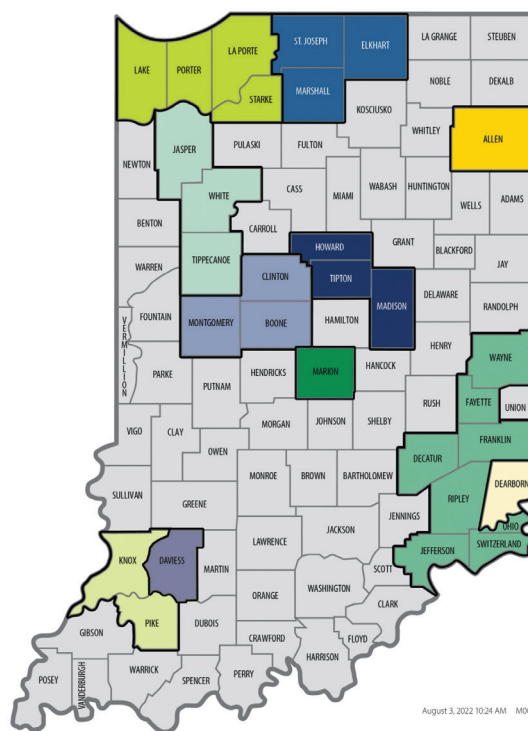


Figure 6: Overview of MIRS Sites

MIRS site	Model	Description	Counties	Staff
Beacon Health Group with Oaklawn Psychiatric Center	1	Program is run through Oaklawn CCBHC.	Marshall, St. Joseph, and Elkhart	26 peer recovery coaches; therapists, clinical staff, and interns
Daviess Community Hospital	1	Program is run from the ED within Daviess Community Hospital.	Daviess	Five peer recovery coaches who also provide transportation support to their clients as needed. One supervisor, no clinical staff.
Health & Hospital Corporation with Eskenazi Health	1	Program is run by the adult addiction department of Eskenazi Health.	Marion	Six peer recovery coaches, plus a team lead, case manager, and program manager.
Good Samaritan Hospital	1	Good Samaritan Hospital is the fiscal agent. The program was initially run out of the ED of the hospital. It has since moved into a community space where it shares office space with similar behavioral health-focused organizations.	Knox and Pike	Six peer recovery coaches, one supervisor
HealthLinc	1	Program is run through the HealthLinc Community Health Center (FQHC).	LaPorte, Lake, Starke, and Porter	20 peer recovery coaches, two social workers, one clinical staff, and four team coordinators (one per county)
Integrative Wellness	1	Program is run through InWell’s mental health and SUD services practice.	Boone, Montgomery, and Clinton	Two peer recovery coaches, one therapist, and one nurse practitioner, three staff members
The Lutheran Foundation	3	Program is run as a coalition with the Foundation serving as the grant administrator/ fiscal agent.	Allen	Each partner has at least one peer recovery coach; some have more than one. There is also a mobile team made up of police officers, recovery coaches, social workers and clinicians who go out on outreaches weekly.

Figure 6: Overview of MIRS Sites (Cont.)

MIRS site	Model	Description	Counties	Staff
One Community One Family and Choices Coordinated Care Solutions	2	Program is run as a partnership between the two organizations.	OCOF: Dearborn County Choices: Wayne, Fayette, Decatur, Switzerland, Jefferson, Franklin, Ripley, and Ohio Counties	<p>The OCOF MIRS team has the following staff</p> <ul style="list-style-type: none"> • 2 Emergency Response Clinicians • 2 Recovery Support Specialists • 1 Care Coordinator • 1 Wraparound Facilitator • 1 Program Director <p>The Choices MIRS team has the following staff</p> <ul style="list-style-type: none"> • 6 Recovery Support Specialists • 3 Emergency Response Clinicians • 1 Recovery Wraparound Facilitator • 1 Program Manager
Turning Point SOC	2	Program is part of the recovery support services provided by Turning Point.	Howard, Tipton, Madison	One project director, four peer recovery coaches, two addictions therapists, one psychiatrist, one nurse practitioner, and two RSC peer techs.
Valley Oaks Health with Phoenix Paramedics	2	Program is part of a larger community behavioral health response. Valley Oaks is the fiscal agent, with Phoenix Paramedic Solutions leading the implementation.	Tippecanoe, White, and Jasper	16 peer recovery coaches; 13 of which are trained as CHWs or CRS and three are bilingual

While all the partners served as referral sources for the MIRS program, the nature and extent to which the sites worked with the partners differed based on the three types of MIRS site models.

1. **Model 1:** The MIRS site is currently a Certified Community Behavioral Health Clinic (CCBHC), hospital, Federally Qualified Health Center (FQHC), or primary health care provider. At sites where the MIRS program was affiliated with a parent health care facility, the MIRS sites mostly relied on the partners for referrals and to support their community engagement.
2. **Model 2:** The MIRS site is a behavioral health, addiction treatment, or recovery support services provider. At sites where the MIRS program was part of a larger

community behavioral health response, the MIRS sites worked very closely with partners to deliver a package of services across the continuum of care.

3. **Model 3:** The MIRS site is an independent organization. At these sites, two kinds of partnerships were formed; those funded to implement the MIRS program elements and the non-funded partners whom they relied on for referrals and community engagement.

Regardless of the nature of the engagement with partners, there was consensus among the MIRS sites that working with community partners was essential to the success of the program as these partnerships help the MIRS site fulfill its objectives and meet client needs.

Figure 7: MIRS Site Models

Model 1



Model 2



Model 3



“[Community partnerships] really help the people we work with get the best services; they don’t have to worry about working with one agency and can just focus on their recovery, while everyone is chipping in and helping where they can.”

– Integrative Wellness

The community partners the MIRS sites typically work with include:

- Behavioral and physical health care service providers
- Community corrections
- Community mental health organizations/centers
- Department of child services
- Employers
- Families
- First responders
- Food pantries
- Homeless shelters
- Integrated Reentry and Correctional Support (IRACS) program (when possible)
- Jails
- Police
- Probation
- Sheriff’s department
- Transitional facilities
- Treatment centers/facilities

Additionally, some sites had unique partnerships that others may wish to replicate. These included:

- Attorneys
- Universal prevention providers
- Harm-reduction focused organizations
- Schools
- Youth-focused organizations

The teams who did not have relationships or partnerships with these stakeholders expressed the desire to build these relationships as they considered these stakeholders essential to the recovery services ecosystem.

While all the teams greatly valued the partnerships built with their community, almost all noted that stigma against SUD remains a barrier to effectively building some relationships. Although the MIRS program has been instrumental in changing the attitudes and removing the stigma associated with recovery, these issues persisted and serve as barriers to building strong and effective relationships with community partners.

CONSISTENT QUALITATIVE FINDINGS ACROSS ALL MIRS SITES

After the site visits, the THS team compiled detailed summary notes. The team then analyzed the notes and identified consistent themes, as outlined below.

Limited transportation options

Seven percent of households in Indiana do not own a vehicle, according to the [Indiana Department of Transportation](#). Households in poverty typically have lower vehicle ownership rates, increasing their reliance on public transportation. Several MIRS sites shared that there were limited public transportation options available. One MIRS team noted that transportation is one of the two biggest barriers

for clients accessing treatment services along with funding. To address transportation barriers, some teams established separate transportation assistance programs or provided bus passes to their clients. This challenge is so pronounced that, in one example, a site used funding from another grant to buy vehicles for their peer coaches to provide direct transportation for clients to treatment programs. These coaches at this site noted that even with the vehicles, client transportation needs far exceeded their capacity.

“We realized that close to 50% of our clients had transportation needs and couldn’t get to treatment. Following this, we were able to provide bus passes to clients.”

– The Lutheran Foundation

Lack of housing

Several sites shared that the lack of resources to cater to populations currently unhoused was a significant barrier to effectively supporting their clients. Two sites shared that although the community had resources to support affordable housing (e.g., housing assistance programs), oftentimes, their clients could not access these resources due to prior justice involvement. For instance, landlords would decline housing after completing a background check. Another site shared that there was limited transitional housing available within their community, and these facilities often did not accept clients with certain attributes [e.g., couples, pregnant individuals, transgender individuals, those with high-need health care conditions, or individuals on medications for opioid use disorder (MOUD)]. Another site shared that there were no homeless shelters close to their facility or within the community, and the closest one, which was a 45-minute drive, was usually always full.

“Transportation and housing are major issues for patients – a lot of our time is spent coordinating this.”

– Beacon Health Group with
Oaklawn Psychiatric Center

Providing care navigation functionality

Several teams shared that the MIRS peer recovery coaches have helped fill staffing gaps, particularly with respect to navigation and linkage services within the recovery services ecosystem. For example, at one of the sites, the sheriff stated that the MIRS team had relieved the sheriff department’s personnel of responsibilities that they would normally have struggled to execute, especially around helping individuals with an SUD who are justice-involved. Another site shared that the MIRS team has helped reduce clinical staff time spent on system navigation issues freeing them up to provide additional clinical services. Several other jail administrators and law enforcement personnel across most of the sites also expressed that the services provided by the MIRS teams provide important diversion and deflection from the justice system, especially reducing periods of incarceration and lowering recidivism for individuals with SUDs.

Medications for opioid use disorder (MOUD) adoption

Although the provider community has adopted medications for opioid use disorder (MOUD), several sites expressed a desire to offer MOUD more broadly. However, expansion to other venues such as the local jail, depends on the attitudes of the community and the local sheriff’s department, and the limited opportunity to expand funding to these services within carceral settings. Sites indicated although stigma towards use of MOUD was pervasive, it was important to offer it as an option for individuals in need and who

might request it. Several teams cited community stigma and discrimination towards individuals who participated in MOUD negatively impacted the effective rollout of MOUD services within such counties. On the other hand, another site whose sheriff was very supportive of MOUD was able to establish a MOUD clinic within the county jail.

“They have changed the mindset in the jail as inmates who knew them as fellow inmates during their time in jail now see them come through the doors as staff - and not just staff, respected members of staff! The officers see them too, and this has changed their mindset toward recovery. It has been very encouraging for the inmates.”

– Daviess Community Hospital

Community attitudes

Several sites shared that the work of the MIRS team has contributed immensely to changing the community’s attitudes toward SUD and recovery. A partner at one of the sites noted that the attitudes and levels of empathy of police officers towards individuals in recovery have changed dramatically since implementation of the MIRS program. Another shared that seeing law enforcement officers work with the MIRS team has also impacted how the community views their law enforcement personnel as no longer only punitive, but supportive community resources. A member of one of the law enforcement teams noted that they knew the program was making an impact when the police force’s gang unit raided a home and instead of immediately taking them into custody, they called the MIRS team and recommended that several individuals needed treatment instead of incarceration.

“In addition to all the service that we have been able to provide, a major win for us is that we are seeing physicians buy into this program.”

– The Lutheran Foundation

DMHA partnership

All the sites described DMHA as a very responsive and resourceful partner. There was consensus that working with DMHA has been a pleasant experience, with supportive technical assistance when needed. One site noted that DMHA treated all their questions and concerns with utmost seriousness and urgency. Another shared that the DMHA team always solicited for and implemented provided feedback to the best of their ability. A few sites also noted that DMHA has been helpful in troubleshooting issues that arise in relation to completing and uploading the GPRA forms, and provided technical assistance when changes were made to GPRA reporting.

Limitations on eligible use of grant funds

Several teams shared that the grant requirements limit them to only serve individuals with opioid or stimulant use disorders, which poses a challenge as they often encountered individuals with alcohol use disorders (AUD) or another SUD. One team shared that when they began operations, limiting services to individuals using opioids or stimulants was a major challenge. Over time this team established partnerships with other organizations that support individuals that are outside the grant fund limits. Another shared the emotional burden of not being able to support all individuals in need due to grant restrictions. Although this was a challenge expressed by most teams, several have devised innovative ways involving partnerships with other organizations to cater

to individuals excluded by the SOR program or simply provided the needed service pro bono to the community. Finally, limited funding precludes sites from being able to address critical Social Determinants of Health (SDOH) issues that can impact long-term recovery, such as housing, food insecurity, educational opportunities, and employment, to name a few.

“A lot of people need help, not just folks with opioid use disorders.”

– Turning Point SOC

“The MIRS funding is providing our community and its programming the flexibility to adapt to the ever-changing environment of addictions and recovery. As the substance of choice changes and we deal with increasingly more dangerous substances, we have found that our approach needs to adapt and change with it.”

– Phoenix Paramedic Solutions

SUMMARY OF QUALITATIVE COMMUNITY BENEFIT FINDINGS

At each site visit, partners spent significant time detailing the positive benefit of MIRS in their community. The mobile services enable MIRS teams to take a proactive approach and respond quickly to emerging needs. The mobility aspect of the program allows for a proactive approach, as peers can respond quickly to emerging needs. Moreover, the enhanced presence of peer recovery support within the community fosters a unique and empathetic connection with individuals seeking help, as peers can identify with individual struggles through a shared lived experience. This connection promotes trust, reduces stigma, and encourages more individuals to seek support for their opioid use or stimulant use disorders. Additionally, MIRS has provided a vital workforce development pathway, especially for peers throughout Indiana.

As a result, the overall community benefits from decreased substance-related crises, substance-related law enforcement interactions, reduced emergency room visits, and improved overall quality of life for those in recovery. Additionally, MIRS teams help build a stronger sense of community by fostering collaboration between various organizations and stakeholders, all working towards a shared goal of supporting individuals on their recovery journey. The addition of MIRS in a community has generated a positive ripple effect, transforming communities into more resilient, supportive, and compassionate environments for everyone.



One Community One Family & Choices Teams

DATA AND OUTCOMES

Overview of data collection processes

The GPRA data collected by the MIRS sites provides a foundation to analyze the outcomes and effectiveness of the programs in the community. While data limitations exist, such as bias and self-reporting concerns, the analysis identifies several areas of success and positive outlook across the MIRS program showing the value to the community and the state. The following section shares key findings in the data that can be applied to the overall key performance indicators of the MIRS program.

During the site visits, MIRS teams described how they collect data and administer the GPRAs. Several assign recovery coaches with the responsibility for conducting the initial GPRA and intake assessment. Of those, five also assign recovery coaches to do the six-month follow-up GPRA; one has the team lead conduct the six-month follow-up GPRA and upload the GRPAs; and one has the supervisor conduct the follow-up GPRA and upload the GPRAs. Three sites use personnel other than a peer recovery coach to conduct the initial and follow-up GPRAs. One tries to combine their intake assessment with GPRAs, so whoever does the intake/has the initial contact administers the initial GPRA. The follow-up GPRA is completed by peer/staff responsible and sent to the “peer in charge” who reviews and uploads all GPRAs. Another has the individual-funded partners administer both the initial and follow-up GPRAs. The completed GPRAs are shared with the data lead, and that person uploads the completed GPRAs. The third uses clinical staff on the team to administer the initial and follow-up GPRAs. In administering the GPRAs, the staff mostly do not approach it as a structured interview but focus on having conversations and collecting the information as the dialogue evolves.

All sites referenced that they are utilizing GPRA and various site-specific data to:

- Track referrals and returning clients;
- Write weekly and monthly reports;
- Identify barriers to accessing recovery services;
- Pinpoint gaps in services;
- Ascertain unmet needs in the community;
- Track outcomes and impact;
- Obtain feedback from clients on ways to improve the services and the overall program;
- Educate community partners;
- Inform decisions on resources allocation;
- Improve program offerings, and;
- Identify what grant opportunities to pursue.

Several sites utilize spreadsheets and internal scorecards to track data, while others utilize technology platforms. Several examples include:

- One site uses “Recovery Link,” an EHR built specifically for peers to collect data. The questions on Recovery Link focus on gathering data on mental health or substance use recovery programs that the clients may have been exposed to or participated in, including any overdose history/treatment information.
- One site provides the peer recovery coaches access to Epic (an EHR system) and allows them to update the medical records of their clients as appropriate.
- One site uses “Freesia,” an internal intake assessment tool for collecting data on referral sources, diagnosis, and follow-ups, is used by one of the sites.
- One site has a dashboard that aggregates data from all their data sources and allows them to use the data for decision-making in real-time.
- One site is currently working on a dashboard that will aggregate all the data it collects from the different sources and summarize the findings.

Since each of these individual sites has a unique supplemental database, the following analysis focuses on the GPRA tool and data used by all sites.

Background

The GPRA data set used in THS' analysis is not consistent across all sites. The proportion of surveys reported, as well as the timeline of first intake and last intake, vary. Full aggregate data was available from April 2019 through December 2021. Data that is available through December 2022 is included in the analysis, however, this data is incomplete as of the publication of this report. Appendix A provides an overview of intake data collection start dates used in this analysis.

Interview Completion

MIRS sites are expected to collect GPRA data through client interviews at intake/point of entry into services and complete a reassessment at six months and at program discharge. The overall completion of six-month follow-up interviews is 59 percent. The total number of interviews and subsequent follow-up interviews varied by site. The sites with the highest percentage of completion of a six-month follow-up after an intake interview were Valley Oaks/Phoenix Paramedic Services (84 percent), The Lutheran Foundation (72 percent), and HealthLinc (68 percent). This is not an indication of success but rather an opportunity to identify best practices that may be disseminated across other MIRS sites. Furthermore, the data may have different meanings across each site and, therefore, must be used to manage performance at an individual site rather than a benchmark across all. For instance, some sites state that a person is discharged the same day as their six-month follow-up, while others identify discharge as a separate event. To use this measure as a performance indicator across sites, there must be a consistent measurement method instilled and followed universally throughout the MIRS program.

However, in tracking across the entire MIRS program in the aggregate in Figure 8, data through the end of 2021 shows consistent growth in the volume of interviews reported, with a strong push for an increase in follow-up interviews and discharges at the start of 2022. Incomplete data for 2022 prevented THS from evaluating whether this trend in growth continued.

Figure 8: Total Interviews in Data

Intake	<i>2,698 Intake interviews completed</i>
6-month follow up	<i>1,600 six-month follow up interviews completed</i>
Discharge	<i>940 clients with discharge noted in data</i>
Total number of interviews:	5,238

Demographics

The demographic makeup of each site is important to consider in the context of the services provided and outcomes achieved. The data below is based on all individuals who

Figure 9. Gender Demographics in GPR Data Set

GENDER	FREQUENCY	%
Male	1,476	54.7%
Female	1,217	45.1%
Transgender	5	0.2%
Other, Refused, Missing Data	0	0.0%
TOTAL	2,698	100%

Figure 10. Race/Ethnicity Demographics in GPR Data Set

RACE/ETHNICITY	FREQUENCY	%
White	2,388	88.2%
Black/African American	179	6.6%
Hispanic/Latino	97	3.6%
American Indian	32	1.2%
Asian	7	0.3%
Alaska Native	2	0.1%
Native Hawaiian or Other Pacific Islander	3	0.1%
Other	0	0.0%
TOTAL	2,708	100%

completed an intake interview at any site. Across all MIRS programs, slightly more than half (54.7%) of the patients served identified as male, and 88 percent stated White as their race/ethnicity, as shown in Figure 9 and 10 respectively.

Across all sites, the average client age was 36 years old, with the oldest client being 78 and the youngest 14. Eskenazi had the highest median age of people served, at 45, nine years higher than the average age across the state. Turning Point had the youngest average age of 33.

Discharges

Over the period of the study, 940 clients were identified as discharged in the data. Thirty-one percent of discharged were identified as completed or graduated, while the remaining 69 percent were terminated. Choices and The Lutheran Foundation recorded the largest percentage of graduated clients (72 percent and 40 percent, respectively). There are several reasons a client may be terminated from the MIRS site. The most common reason for termination is “involuntarily discharged due to nonparticipation” (44.6 percent) and “left on own against staff advice without satisfactory progress” (8.4 percent). MIRS sites do not track discharges with the same fidelity across sites and, therefore this metric as it is used today should not be used as a comparative measure of success.

Baseline Intake Data

Employment

At intake, 34 percent of clients were either employed or attending school. Thirty-two percent (869 clients) were employed full or part-time with 679 employed full-time and 190 employed part-time. Of the 1570 unemployed, approximately 43 percent were looking for work, 40 percent were not looking for work, and 12 percent were disabled. Over 300 clients (304 clients) were planning some kind of employment coaching (pre-employment services or employment coaching).

Housing Stability

Clients have various housing statuses upon entering the MIRS sites. Most clients, 67.6 percent, indicated they were “housed” at intake. Of those, 46.3 percent own/rent an apartment, room, or house; 37.4 percent live in someone else’s apartment, room, or house; and the remaining 16.3 percent resided at either a halfway house, residential treatment, another housing situation, or had missing data.

Of the 32.4 percent who indicated they were not housed at intake, 20.7 percent said they were in an institution, 7.9 percent indicated they were living in a shelter, 2.5 percent indicated they were living on the street/outdoors, and 1.3 percent refused or didn’t know. According to DMHA, nearly all individuals living in an institution is referencing a correctional facility.

Criminal Justice Involvement

The GPRA assessment includes three required intake questions to determine clients’ recent history with the criminal justice system. In the study period, nine percent of clients reported being arrested at least once in the past 30 days upon intake. Thirty-one percent of clients responded that they were currently awaiting charges, trial or sentencings, and 39 percent responded that they were currently on parole or probation.

Emergency Room Utilization

Upon intake, 16 percent of clients reported some sort of emergency room involvement in the 30 days prior to their intake.

Service Utilization

To identify the services most used at the MIRS sites, the analysis identified the total and average number of service days as defined by SAMHSA for the 940 clients in the discharged data. The GPRA questionnaire requires the completion of how many “service days” for each delivered service was conducted for each client. Therefore, THS can identify service utilization in the aggregate.

The GPRA asks clients to identify the number of days of services provided to the client during the client’s course of treatment/recovery by modality. The most common service modality of the client cohort was case management and recovery support services. On average, 15.36 case management sessions are conducted per all discharged clients. While at the MIRS site, 277 clients received, on average, 52.13 sessions of case management. For recovery support services, on average, 14.01 sessions were conducted per all discharged clients. Almost 800 clients (773 clients) received on average each of 17.04 sessions of recovery support services.

The most common treatment services deployed to clients included treatment planning (346 clients), screening (325 clients), and referral to treatment (454 clients) as reported upon discharge. Within case management, individual coordination was provided to 178 clients. On average, clients with individual coordination case management had 12.76 service sessions and clients with family services case management had 21.67 services. The most common peer to peer services deployed were peer coaching (740 clients) with an average of 9.86 sessions per client. For individuals who engaged in peer coaching, they had, on average, 12.53 services.

Outcomes

The following outcomes were analyzed based on a cohort of 871 clients who had completed the GPRA assessment at intake and at the six-month follow-up. This cohort represents 32.5 percent of all intakes conducted during the study. The outcomes in Figure 11 are defined by SAMHSA’s SPARS database (see Appendix A).

The change in outcomes indicated on the intake form compared to six-months follow-up show positive impact for abstinence, employment, and education attendance, mitigating drug/alcohol-related consequences, stability in housing, and ED involvement.

Figure 11: Outcomes from Intake to 6-Month Follow-Up GPRA Assessments

OUTCOMES	INTAKE		FOLLOW UP
	Percentage of individuals indicated this outcome on the intake form N= 2,674	Percentage of people who indicated this outcome on the intake form AND had a corresponding 6 month follow up N=871	Percentage of clients who indicated the outcome on 6-month follow-up N =871
Abstinence: did not use alcohol or illegal drugs in the past 30 days	54%	51%	69%
Crime and Criminal Justice: had no past 30-day arrests	89%	90%	87%
Employment/ Education: were currently employed or attending school	34%	37%	50%
Health/Behavioral/Social Consequences: experienced no alcohol or illegal drug related health, behavioral, social consequences in the past 30 days	57%	60%	71%
Social Connectedness: were socially connected	85%	86%	79%
Stability in Housing: had a permanent place to live in the community	32%	38%	44%
Emergency Department: had involvement with the ED in the past 30 days	16%	18%	9%

Further outcomes are identified based on a Likert scale scoring for a change in self-reported quality of life and satisfaction with personal relationships in Figure 13. The number of individuals who responded to these questions on the GPRA differ slightly as it was possible for clients to indicate “refused” or “don’t know” as answers to these questions.

There are improvements in the average score for both questions on the quality of life and relationship satisfaction from intake to six -month follow-up questionnaires.

Figure 12. Quality of Life and Social Connectedness Outcomes

QUESTION	INTAKE		FOLLOW UP
	Average score of clients at intake	Average score of clients who answered this question on the intake form AND had a corresponding six-month follow up	Percentage of clients who indicated the outcome on 6-month follow-up
How would you rate your quality of life? Responses are on a Likert scale ranging from 1 “Very Poor” to 5 “Very Good”.	3.4	3.61 N=761	3.83 N= 761
How satisfied are you with your personal relationships? Responses range from 5 “Very Dissatisfied” to 1 “Very Satisfied”.	2.4	2.26 N=765	2.08 N=765

Medication Assisted Treatment (MAT)

Medication-assisted treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of opioid use disorders. For this section of the analysis, THS is using MAT rather than MOUD language since that is the way it appears in the GRPA data and how the tool is administered in the field. The GPRPA data show that 296 out of 2672 clients (11 percent) were planned for and/or received pharmacological treatment services through their MIRS involvement. Integrative Wellness, Oaklawn, and Choices recorded the highest utilization of MAT as a treatment pathway.

Figure 13 shows outcomes measured at intake and follow-up split between those who had planned or received MAT and those who had not. We include planned services because an accounting of actual services delivered is only done at discharge, and this would exclude too many observations of active clients with follow-up interviews. The final number of MAT clients with follow-up information was 111. The response rate for MAT clients on follow-up is 67 percent, much higher than the response rate for non-MAT

of 49 percent. This indicates success for one of the primary goals of MIRS – to keep individuals engaged in health-related services to reduce other criminal justice or ED involvement.

The data show a 65 percent increase in the number of MAT clients maintaining abstinence from intake to follow-up. On follow-up, a larger share of MAT clients reported no use of alcohol or illegal drugs in the past 30 days than the share of non-MAT clients, despite having lower abstinence numbers at intake. Overall, MAT clients saw their outcomes improve at a higher rate than non-MAT clients for all measures except for housing.

Quantitative Data Analysis Summary

GPRPA data can be challenging to capture as it relies on client engagement and bandwidth within the MIRS team. The data collection trends over time indicate an increase in intake and six-month follow-up assessments from the MIRS program’s beginning through the available data period analyzed. The MIRS sites have integrated best practices and localized approaches to increase client engagement with this data continuously.

Figure 13: Outcomes Measured at Intake and Follow-up

	INTAKE		6 MONTH FOLLOW UP		% CHANGE	
	MAT	No MAT	MAT	No MAT	MAT	No MAT
Abstinence: did not use alcohol or illegal drugs in the past 30 days	46%	54%	76%	68%	65%	26%
Crime and Criminal Justice: had no past 30 day arrests	76%	91%	86%	87%	13%	-4%
Employment/ Education: were currently employed or attending school	24%	34%	41%	51%	71%	50%
Health/Behavioral/Social Consequences: experienced no alcohol or illegal drug related health, behavioral, social consequences in the past 30 days	43%	64%	57%	74%	33%	16%
Social Connectedness: were socially connected	66%	85%	69%	80%	5%	-6%
Stability in Housing: had a permanent place to live in the community	33%	31%	38%	45%	15%	45%

The GPRA data also helps identify the utilization of services at the MIRS sites in determining which services are more frequented and for how many “service days.” In aggregate, case management and recovery support services are the most utilized. This aligns with site visit qualitative findings. THS concludes this is attributed to the strength of relationships the MIRS teams build in the communities with the individuals participating in the program.

While there are various limitations in conducting data analysis on the available GPRA data, the aggregate outcomes available showed improvement in access to social needs, such as a decrease in consequences related to substance or alcohol use. THS cannot generalize findings due to the significant drop-off of clients who complete an intake and do not complete a six-month follow-up.

However, when comparing the cohorts who have received both screenings, they have similar intake scores for almost all categories which indicates limited bias and selection contributing to the positive impact on outcomes.



35 percent increase in abstinence of alcohol or illegal drugs



50 percent decrease in individuals reporting ED involvement



37.5 percent increase in individuals reporting stable housing

KEY DATA FINDINGS

The quantitative analysis was instrumental in helping THS develop recommendations described later in this report. Five key findings include:

1. **Follow-ups help improve outcomes.** For those with follow-up data, outcomes are very positive. There are marked improvements in abstinence, employment, absence of negative consequences from substance use, housing stability, as well as self-reported quality of life measures. This should motivate sites to perform and report more follow-ups.
2. **Self-help group participation increases social connectedness.** While social connectedness measured by attendance at voluntary self-help groups falls slightly for those with follow-ups, overall self-reported satisfaction with personal relationships improves. This could be an indication of strong peer bonds.
3. **Justice involvement measured by number of arrests in the past 30 days remains flat.** Given that peers first engage with clients at various stages of justice involvement, including clients who are institutionalized, it may be worthwhile to explore different ways to measure impact in this domain for justice-involved individuals. Additionally, it is important to note that there is only six months between intake and follow-up; therefore, a measure like this may take longer to materialize given the length of traditional court cases, parole, and probationary periods.
4. **Quality of data needs to be improved.** The SOR 3 refactoring has caused missing information and time lag. Additionally, it is critical that sites create a system that allows for discharge tracking and regular follow-ups. Current data shows measurable positive outcomes for those involved (clients, peers, and community) however, lack of follow-up data limits our ability to provide a full picture of long-term impact.
5. **Leverage service utilization data.** Service utilization data should be leveraged for future sustainability analysis by tracking what services are performed most and exploring opportunities for compensating for those services.

BEST PRACTICES, LESSONS LEARNED, AND CHALLENGES

The following section provides a summary of strategies and approaches that have proven effective in tackling challenges, achieving success, and fostering growth. These best practices, lessons learned, and challenges are provided to promote continuous quality improvement and provide valuable insights that can benefit each MIRS site.

“For a long time, all our behavioral health programs wanted to have a peer recovery coach. The MIRS grant has allowed us to hire peer recovery coaches that served the entire ecosystem without having to immediately worry about sustainability and compete for workforce development.”

– Good Samaritan Hospital

Workforce benefits

The inclusion of peer recovery coaches as a cornerstone of the program proved significant, especially considering the limited reimbursement options available through other means. For most sites, the MIRS funding was the only viable way to secure payment for these coaches, making it an invaluable resource.

The peer recovery coaches also filled a crucial gap in the existing support structure for individuals seeking recovery. These coaches provided vital navigation support, which had been missing from the recovery community’s current services. Several sites had already been exploring the peer model, so when MIRS made it possible to implement, it was warmly welcomed as a much-needed enhancement.

The peer role held immense meaning and reward for the peers themselves. Many of them expressed gratitude for the opportunity to engage in such meaningful work and utilize their own experience to make a positive impact. Many also stated they found their role fulfilling in ways they might not have experienced elsewhere.

One notable strength of the peer recovery coaches was their ability to engage with the community on a personal level. They met individuals right where they were, making their approach highly effective and impactful. Interestingly, the influence of the peer recovery coaches extended beyond their immediate impact on clients. In some cases, clients who had worked with these coaches and recognized the value of their support expressed interest in becoming peer recovery coaches themselves, illustrating the program's empowering effect.

Additionally, the low peer recovery coach turnover rate across all sites was a testament to the success of the program. The stability of the team further strengthened the program's effectiveness in providing continuous and reliable support to those on the path to recovery.

Overall, the integration of peer recovery coaches proved to be a game-changer, offering indispensable support, empowering those in recovery, and fostering a sense of purpose and fulfillment among the coaches themselves. The program's success, combined with the dedication of the peer coaches, contributed to its positive impact on the recovery ecosystem, added a valuable role within the SUD workforce, and provided hope for a promising future for individuals seeking recovery.

"They help do the leg work that needs to be done to integrate these folks back into the community."

– One Community One Family & Choices Coordinated Care Solutions

Workforce challenges

The current behavioral health [workforce crisis](#) impacted most teams' ability to make timely referrals for SUD or related health care services. Smaller rural communities have been hit particularly hard by a lack of qualified mental health and SUD professionals. According to [HRSA](#)



HART Team (The Lutheran Foundation)

as of September 2023, there are 101 designated Mental Health Professionals Shortage Areas impacting over 6.6 million residents. One region that stood out was Clinton County, where staffing shortages were so widespread that several brick-and-mortar facilities had to close their doors due to the lack of qualified personnel.

The shortage of staff became even more evident when it came to recruiting case managers. Several teams noted significant challenges in finding enough qualified individuals to meet their needs and provide the necessary support to those seeking help. In cases where immediate services were unavailable, the presence of the peer recovery coach proved invaluable in maintaining a connection with the client in need.

Despite the presence of valuable services provided by the MIRS team, some locations were not fully utilizing them, with hospitals and the sheriff's department being mentioned as examples. The underutilization was attributed to stigma surrounding SUD and a lack of understanding about the breadth and effectiveness of the MIRS services.

Certification hurdles further compounded staffing needs. Multiple sites expressed difficulties in obtaining certification as Licensed Clinical Social Workers (LCSWs). The demanding number of required hours and the paperwork burden make the process arduous. Additionally, certification courses were limited to only two presenting entities and were consistently at full capacity, making it challenging for coaches to access the necessary training.

While the current behavioral health workforce crisis has posed significant challenges for MIRS teams, the presence of peer recovery coaches has been a beacon of hope, bridging the gap and maintaining crucial connections with clients in need. Addressing these workforce challenges and promoting awareness of available services are vital steps in ensuring that all individuals, regardless of their location, have access to support and resources. Collaborative efforts are essential to overcome these obstacles and build a more robust and resilient workforce that can effectively serve the diverse needs of the community.

Client support

Many peer recovery coaches underscored the significance of assisting their clients in obtaining

identification documents such as social security cards and licenses. Clients can often face the challenge of not having any identification papers, which can greatly impede their recovery progress. This lack of identification negatively impacts their ability to secure stable employment and access essential public benefits. While securing identification documents for clients is not a grant requirement, the coaches unanimously agreed that providing this assistance was critical to setting their clients up for success in their recovery journey.

Coaches also highlighted the importance of diligent note-taking and tracking throughout their interactions with clients. They emphasized that these practices are indispensable in providing effective support. By meticulously recording the details of each engagement, the coaches can better understand their clients' progress, challenges, and evolving needs over time and foster deeper connections and trust with their clients. Through the course of their work, they have honed and strengthened their tracking and notetaking capabilities, recognizing the immense value it brings to tailoring their support to suit each individual's unique circumstances.

As a collective, the coaches have witnessed the power of these strategies in making a meaningful impact on the lives of those striving for recovery, solidifying their commitment to maintaining these practices and continuously enhancing their capabilities in helping individuals on their recovery journey.

"A lot of the times, peers are the first people clients call if they ever return to substances. That puts us in a great position within the treatment team—then we can offer support immediately."

**- Health & Hospital Corporation
with Eskenazi Health**

GPRA/Data collection

The MIRS teams have learned valuable lessons in the realm of data collection best practices. One MIRS site recommended separating intake assessments and GPRA data collection from the same visit, as patients can feel overwhelmed by the process. Conversely, some sites preferred to combine the assessment and GPRA intake to minimize redundancy. These two vastly different approaches highlight the importance of customizing the data collection process to meet the specific needs of the on-the-ground team.

participants in their recovery journey. Teams also shared that waiting until a rapport was built with the client instead of trying to complete the GPRA at the initial contact was a helpful strategy, as was leveraging relationships within the community to track clients down at the time of follow-up. One site shared that they usually know which organizations their clients are involved with (e.g., probation) and can reach out to them when trying to locate the client for follow-up.

Lastly, utilizing the six-month follow-up to demonstrate progress helped to empower clients, keeping them engaged and invested in their path to recovery. These lessons offer valuable insights for optimizing data collection practices and maximizing the positive impact of recovery support services.

Sustainability

During every site visit, THS asked the MIRS team “How are you planning for the sustainability of the program? What, if any, other sources of revenue do you have?” While responses varied in detail, most MIRS sites shared that sustainability was one of their greatest concerns and that if the MIRS grant was no longer available, their programs would likely be shuttered. One team stated that if the funding got terminated, the program would crumble, and the community would be plunged

into a state of crisis. Another noted that if the funding went away, although a few of the partners may still be able to continue with the work, the collaborative nature of the work (as it is now) would greatly suffer. They explained that the funding allowed for collaboration which significantly adds value as it gives them access to partners and resources that they would not have been able to access on their own.



Integrative Wellness Team

MIRS teams also emphasized the importance of prioritizing data collection early to ensure a comprehensive view of program outcomes and prevent future struggles. Several teams noted that streamlining the process by designating one person to oversee data collection and uploads helped the site’s organization and efficiency.

Additionally, MIRS teams shared that explaining the benefits of the GPRA form to clients fosters their willingness to participate, making them active

One team shared that running a MIRS site is expensive because of the different kinds of personnel that make up the team, including EMS, police officers, and behavioral health clinicians. The MIRS team stated that if the MIRS grant was terminated, in order to continue the program, they would need to have discussions with the different partners to determine if their organization/entity could financially support the MIRS work. Another MIRS site said that if a foundation would be willing to step in and help with funding, they may be able to provide support if the grant ends, while still another said that the local Community Health Center has the capacity and would most like absorb the peer recovery coaches and bill Medicaid for their services.

One MIRS site, located within a hospital, is in the process of becoming a Recovery Community Organization (RCO). Thus, if the MIRS funding is discontinued, its peer coaches could potentially be paid through the Indiana Recovery Network. Recovery Works could also reimburse peers that teach matrix classes within the jails. The team's leadership also plans to branch out into more clinical work using the CCBHC model. Since the CCBHC model requires peers, this creates a potential vehicle for compensating the peer recovery coaches. A second site also said they would attempt to leverage CCHBC funds if needed.

“Please keep the program going. If it wasn't for this program, I probably would have relapsed.”

– HealthLinc Client

Grant limitations

Several MIRS sites stated that there is currently a limited number of therapists within the community, and funding to support their work is also limited. There are also limitations to whom the MIRS team can serve because of the grant funding limitation to specifically serve patients with opioid or stimulant use disorder. A few

sites noted that this limitation was particularly challenging because their team must turn away individuals with alcohol use disorders. One site directs these patients to other partners with the resources to help; another started a “[recovery café](#)” to ensure all clients, regardless of their diagnosis, have access to recovery coaches.

“This is hard for clients too; they see another person getting help for a similar problem, but they can't get funded.”

– Phoenix Paramedic Solutions

As detailed in the Limitations section, another significant challenge faced by MIRS personnel is the mismatch between the GRPA tool and the nature of the services delivered. While the GRPA tool may be a valuable assessment and data collection instrument for certain programs, it may not be the most ideal fit for recovery support services and social determinants of health measures. These services often involve personalized and holistic approaches to address the unique needs of individuals on their journey to recovery. The length and standardized rigid structure of the GRPA tool might not adequately capture the nuances and complexities of the support provided, potentially leading to incomplete or inaccurate representations of the program's impact. As a result, there is a risk of overlooking essential elements that contribute to the success and effectiveness of recovery support services.

STRATEGIC RECOMMENDATIONS

The MIRS program has provided an innovative and flexible cross-sector-driven approach to a multi-sector local system challenge for certain types of SUD impacting all communities in Indiana. While the federal SOR funding used by DMHA to support the MIRS program since its

inception has enabled sites to fill a significant gap in their communities, the SOR funding's regulatory structure presents significant challenges. DMHA is not able to provide multi-year advanced projections to the MIRS sites, which complicates staffing and operational considerations. If Congress were to authorize the use of SOR funding to encompass more than just opioid and stimulant use disorders, MIRS sites could address a wider range of issues, not turn people away, and better serve the diverse needs of individuals seeking help. THS acknowledges the State of Indiana cannot address some of these core program challenges without the actions of Congress or SAMHSA. Therefore, the following recommendations focus on areas that could be pursued by DMHA or the individual MIRS sites, absent federal changes to the SOR program.

Recommendation #1 – Identify and secure additional funding

Finding and maintaining consistent and additional funding pathways for the MIRS program is vital to ensure its long-term viability, sustainability, and growth. THS recommends that the state explores new approaches to funding the MIRS program by conducting a detailed fiscal and regulatory analysis inclusive of the feasibility for using other state, Medicaid, behavioral health, public health, and justice-related funds to support the cross-sector work taking place. Strategic braiding of funding has the potential to expand MIRS services and number of sites while limiting the sole reliance on SOR funding. New funding pathways should include alternative payment model development that is not solely program-level related funding as it is currently structured, but ties more directly to regionally adjusted patient caseloads and the overall volume of individuals served by individual MIRS sites inclusive of quality measure incentives. These payment pathways and architecture can enhance accountability and further tracking of individual site outcomes.



Recommendation #2 – Set a minimum GPRA data submission threshold

If SOR continues as a primary source of funding for the MIRS program, the participating sites will be required to administer GPRA (despite its noted limitations for use in this context). To maintain accountability and the quality of services provided, THS recommends DMHA requires a minimum GPRA data submission from MIRS sites moving forward. For example, implementing a standard that ensures at least 30 percent of all clients complete a six-month follow-up will help ensure the continuity of data collection and provide valuable insights into the program's effectiveness.

Recommendation #3 – Develop consistent Key Performance Indicators (KPIs)

Given the incongruity of the GPRA tool with the work of MIRS teams, DMHA should develop a separate set of consistent Key Performance Indicators (KPIs) not reliant upon self-report, that each site, in collaboration with the state, is required to track. The following measures could be included as possible KPIs:

- zip code or county-level tracking of fatal and non-fatal overdoses over time within the geography served by the MIRS sites;

- community recidivism rates;
- timely access to MOUD;
- emergency department diversion and follow-up;
- first responder involvement and training;
- percent of unhoused people served to receive housing support, and;
- community recovery readiness indexing and tracking over time.

Recommendation #4 – Work with Integrated Re-entry and Correctional Support (IRACS) Program

It is essential to consider extending the program’s reach to work with all Integrated Re-entry and Correctional Support (IRACS) sites. Collaborating with these sites can significantly extend MIRS reach and support of justice-involved individuals, thereby reducing costs and improving outcomes. Additionally, given the Centers for Medicaid & Medicare Services recent April 2023 guidance with regard to [Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated](#), the state should further encourage MIRS sites to work with local jails to develop additional MOUD services and in-reach services for individuals while incarcerated since new resources may become available in the near term for carceral settings through Medicaid funding.

Recommendation #5 – Implement support networks for MIRS site staff

The impact of vicarious trauma on staff at the MIRS sites can be profound and far-reaching. The staff, including peer recovery coaches, often form strong bonds with those they assist. Unfortunately, the nature of their work means they are not immune to experiencing loss themselves. When clients have a recurrence of SUD or mortality attributable to use of addictive substances, the staff can be deeply affected emotionally. Grief may take a toll on their mental and emotional well-being, triggering

feelings of sadness, guilt, and even a sense of helplessness. Coping with the loss of individuals they have invested time and effort in supporting can be an ongoing challenge, and it may impact their ability to provide effective care for other clients. It is crucial for MIRS-funded organizations to implement support systems for staff that prioritize their well-being, providing access to counseling, peer support networks, and opportunities for self-care and reflection. Such measures can help these dedicated professionals navigate their emotions while continuing to offer valuable support to those on their recovery journeys.

CONCLUSION

Maintaining and expanding the MIRS program is of utmost importance as it offers a transformative approach to addressing SUDs within communities. MIRS programs bridge the gap between emergency services, health care, and recovery support. By bringing recovery support services directly to those in need, MIRS sites significantly improve access to care and resources, leading to positive impacts on many levels.

At the community level, MIRS plays a vital role in reducing the burden on emergency services, jails, and hospitals. By proactively engaging with individuals experiencing a substance use disorder, these systems can prevent crises and lessen the strain on the overall health care infrastructure. Moreover, they foster a sense of trust and support within communities, as residents witness a tangible commitment to addressing the opioid and addiction crises. This fosters a sense of solidarity and collective responsibility, encouraging the community to be more involved in helping individuals on their path to recovery.

For the workforce, MIRS creates opportunities for collaboration and synergy between various stakeholders, including law enforcement, health care professionals, and mental health providers. These systems require a multidisciplinary team



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Peer Based Recovery Support
What Would Recovery Look Like For You?
How Can We Help You Get There?
Valley Oaks with Phoenix Paramedics Team

The ability to receive immediate assistance and follow-up support can prevent the reoccurrence of SUD symptoms and reduce the risk of overdose fatalities. Furthermore, these systems emphasize personalized care, tailoring recovery strategies to individual needs and circumstances. As a result, individuals are provided with the skills and supports needed to achieve sustainable, long-term recovery. The non-judgmental and compassionate approach of the MIRS teams helps reduce the stigma associated with addiction, promoting a healthier and more supportive environment for individuals on their recovery journey.

In conclusion, maintaining and expanding the MIRS program can create profound benefits for communities, the workforce, and individuals in recovery. By facilitating timely access to care, fostering collaboration among various stakeholders, and providing personalized support, these systems can make a significant positive impact. Embracing and investing in such initiatives is a critical step towards building more resilient, empathetic, and healthier societies, where those experiencing SUDs are met with understanding, hope, and the support they need to reclaim their lives.

that can respond to emergencies and provide ongoing support. As a result, MIRS extends the current behavioral health workforce's capacity to tackle SUD-related issues efficiently and holistically. Furthermore, cross-training and knowledge sharing between MIRS sites ultimately fosters a more compassionate and informed response to addiction-related challenges.

Perhaps the greatest value of the MIRS program is for the recovering individual, as the presence of a peer recovery coach can be life-changing.

APPENDIX A

MIRS Site GPRA Collection Timeline

	Client ID Code	First Intake	Last Intake	Notes
One Community One Family and Choices Coordinated Care Solutions	CHO	7/16/19	5/11/22	
Daviess Community Hospital	DCH	12/17/21	5/31/22	Started data collection in SOR 2
Health & Hospital Corporation with Eskanazi Health	ESK	12/18/19	8/25/22	
HealthLinc	HLI	11/12/19	12/19/22	
Integrative Wellness	INT	12/11/20	9/28/22	
The Lutheran Foundation	LUT	10/14/19	10/10/22	
Beacon Health Group with Oaklawn Psychiatric Center	OAK	4/9/19	11/25/22	
Good Samaritan Hospital	SAM	2/8/22	10/17/22	Started data collection in SOR 2
Turning Point SOC	TUP	10/19/21	7/6/22	Started data collection in SOR 2
Valley Oaks Health with Phoenix Paramedics	VAL	9/30/20	11/15/22	Nothing found in SOR 1

Outcome Definitions

- 1. Abstinence: did not use alcohol or illegal drugs** - The total number of all adult and youth cases having indicated the following answer to the questions comprising this GPRA measure. Indicated answers: Question B1_A = 0 and B1_C = 0.
- 2. Crime and Criminal Justice: had no past 30 day arrests** - The total number of all adult and youth cases having indicated the following answer to the question in this GPRA measure. Indicated answer: Question E_1 = 0.
- 3. Employment/Education: were currently employed or attending school** - The total number of all adult and youth cases having indicated the following answer to one or more of the questions comprising this GPRA measure. Indicated answers: Question D_1 = 2 or Question D_1 = 3 or Question D_3 = 1 or Question D_3 = 2.
- 4. Health/Behavioral/Social Consequences: experienced no alcohol or illegal drug related health, behavioral, social consequences** - The total number of all adult and youth cases having indicated the following answer to the questions comprising this GPRA measure. Indicated answers: Question C_3 = 1 or 5 or Question C_4 = 1 or 5 or Question C_5 = 1 or 5.
- 5. Social Connectedness: were socially connected** - The total number of all adult and youth cases having indicated the following answer to the question in this GPRA measure. Indicated answer: Question G_1 = 1 or Question G_2 = 1 or Question G_3 = 1 or Question G_4 = 1.
- 6. Stability in Housing: had a permanent place to live in the community** - The total number of all **adult** cases having indicated the following answer to the question in this GPRA measure. Indicated answer: Question C_1H = 1. The total of all **youth** cases having indicated the following answer to the question in this GPRA measure. Indicated answer: Question C_1H = 1 or Question C_1H = 2.
- 7. *Youth: < 18 Years**

APPENDIX B: ACRONYMS

- | | | |
|---|--|--|
| 1. AUD
Alcohol Use Disorder | 11. FSSA
Family and Social Services Administration | 20. OUD
Opioid Use Disorder |
| 2. CCBHC
Certified Community Behavioral Health Clinic | 12. GPRA
Government Performance and Results Act | 21. RCO
Recovery Community Organization |
| 3. CDC
Centers for Disease Control and Prevention | 13. IRACS
Integrated Re-entry and Correctional Support program | 22. SAMHSA
Substance Abuse and Mental Health Services Administration |
| 4. CHW
Community Health Worker | 14. IRN
Indiana Recovery Network | 23. SOR
State Opioid Response |
| 5. CRS
Certified Recovery Specialist | 15. KPIs
Key Performance Indicators | 24. SPARS
SAMHSA's Performance Accountability and Reporting System |
| 6. DMHA
Division of Mental Health and Addiction | 16. LCSWs
Licensed Clinical Social Workers | 25. SUD
Substance Use Disorder |
| 7. ED
Emergency Department | 17. MAT
Medication Assisted Treatment | 26. THS
Third Horizon Strategies |
| 8. EDA
Exploratory Data Analysis | 18. MIRS
Mobile Integrated Response System | 27. TI-ROSC
Trauma-Informed Recovery Oriented System |
| 9. EHR
Electronic Health Records | 19. MOUD
Medications for Opioid Use Disorder | |
| 10. FQHC
Federally Qualified Health Center | | |

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THIRD HORIZON STRATEGIES

Third Horizon Strategies is a boutique advisory firm focused on shaping a future system that actualizes a sustainable culture of health nationwide. The firm specializes in behavioral health and offers a 360° view of complex challenges across three horizons – past, present, and future– to help industry leaders and policymakers interpret signals and trends; design integrated systems; and enact changes so that all communities, families, and individuals can thrive.