

Transcript:

Using Data to Advance Recovery-Focused Decision Making

Presenters: Jay Chaudhary, Erin Quiring, Ari Nassirri, & Amy Brinkley
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MODERATOR: Hello, everyone, and welcome to our webinar today-- Using Data to Advance Recovery Focused Decision Making. It is presented by the Indiana Division of Mental Health and Addiction. And we are lucky enough to have four speakers with us today.

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And just some housekeeping details. Thank you very much for joining us. If you are having technical issues, please individually message either Stephanie Behlman or Christina Spanbar in the chat section below. Please put your questions in the chat section, and we will have speakers answer them at the end of the session.

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If you would like to see what else the Great Lakes ATTC, MHTTC, or PTTC are up to, please follow us on social media.

Our speakers today are Jay Chaudhary-- Jay is the director of the Indiana Division of Mental Health and Addiction. Previously, he was the managing attorney and director of medical legal partnerships for the Indiana University school of law.

Ari Nassiri works for the Indiana Division of Mental Health and Addiction as the director of behavioral health integration. His responsibilities at DMHA focus on progressing the level of integration across the continuum of care for behavioral health and substance use disorder providers in Indiana, as well as increasing the integration of data sources among providers at the state level. Ari is very excited to work with the recovery support work group, and with their strategy to expand and utilize recovery data.

And Amy Brinkley works for the Indiana Division of Mental Health as the Bureau Chief for consumer and family affairs. She is the chairperson for the NASMHPD's National Division of Recovery Support Services. Her responsibility at DMHA as the national chairperson, primarily focus on the expansion of quality peer recovery, and recovery support service initiatives. She's excited to be part of Indiana's team, advancing the recovery support services and setting the bar nationally for the collection of recovery data.

And Erin Quiring-- Erin works for the Indiana Division of Mental Health and Addiction as the assistant deputy director for quality improvement. Her responsibilities at DMHA primarily focus on monitoring and improvement of treatment services provided by DMHA's certified license, and funded mental health and substance use agencies. Erin is thrilled to be part of this team, using data to expand access to quality, recovery supports through Indiana.

Welcome to all of you. And I'm going to turn it over.

JAY CHAUDHARY: While Amy gets the slides going-- I'm Jay Chaudhary, I'm the director of the Division of Mental Health and Addiction. We are thrilled to be here this morning, or whatever you're seeing this webinar in its recorded form, to chat with you a little bit about DMHA and some of the work that we're doing.

So as the director, my job, I think, can be seen one of two ways, I think. The cynical way is that I just get to take credit for the amazing work that folks like Amy and Ari and Erin are actually doing. And I think, also, as part of that, I get to set the direction and set the why about what we're doing.

And I think I'd like to take a couple minutes before we get to the core of our presentation to explain our why, and explain how the work that we're going to talk about not only was informed by the process of figuring out our mission and vision, but also how that work informs the development of it.

So you know, at DMHA, we are the state the division of the Indiana Family and Social Services Administration, which is our sort of HHS government agency. And we, just like it sounds, we oversee mental health and SUD treatments-- that addiction is in statute, I wish it could be SUD. You know, probably at some point we'll pick that battle, maybe not right now.

And so we set standards for the provision of mental health and SUD services to Hoosiers. And it's a pretty monumental task. And so one of the things I

think many of you that work in government, or work in the public sector probably realize, especially if you're at a high enough level where you have to interact with the community and stakeholders everyday, is that it's a constant push and pull between all these different interests, different groups, different folks telling you that they have the latest, greatest answer to these really complex problems.

I call them purveyors of the silver bullet solution. You know, you'll get an email from somebody saying, if you just authorized my product for Medicaid reimbursement, SUD will be done in the state of Indiana. And I think we all know that's not true. That's one example. Then you also have providers and other folks who are constantly in your ear, asking you to make decisions one way or another.

So over the summer, we came up with a new vision statement. And this vision statement first and foremost is a reminder to us that no matter what else, what other noise we hear, our primary responsibility, and our north star, guiding our decisions, is going to be, what is going to have the best outcome for the mental health and wellness of the people of Indiana? And this has actually been very helpful and useful in a lot of situations, because I think a lot of times people throw a lot of stuff at you, and it's a useful way to cut through a lot of that noise.

Of course, it's not always the easiest thing to answer, right? What is best for the mental health and wellness of the people of Indiana? And so our efforts to answer that question are driven and informed by what we're talking about here today-- that is the data.

And we are embarking on-- and the work we're talking about today is the opening salvo in that process, embarking on a pretty ambitious undertaking to be as data driven as possible. And it really ties back to that vision.

So with that vision, we also developed and have adopted a new mission statement. And I'll read it here. So our mission statement is to champion mental health promotion and substance use disorder prevention, treatment, and recovery systems, that are high quality, seamlessly integrated, and accessible to the people and communities of Indiana.

And Amy, you can go to the next slide. Just to really quickly talk about those. But I think it's important, also, that we put recovery in the mission statement, and that was very intentional. Because one of the things that we observed was that this focus on treatment, you know, while very important obviously, doesn't do service to people-- because recovery is where people spend most of their lives, hopefully.

I mean, recovery is what takes place in the community. Recovery is what takes place beyond that initial treatment. And obviously, there are links, and then there is back and forth between the two, but we thought it was really important to call out recovery, specifically, as something we're focused on.

And then you can see here-- I won't go over all of these, but I think I just want to point out that as you listen to some of the presentation today, just keep in mind how everything that these folks are talking about ties back to these three core principles of the systems that we want to oversee. And that is, high quality, seamlessly integrated, and accessible.

And I think you'll see that the data drives not only the high quality, but also, I think, we want to take it to the next level, and use data to figure out where we are with integration, figure out where we are with accessibility. And then, really use that data as the key that unlocks the door to making the systems that we oversee as close to this ideal as possible.

And so with that, I'll turn it over to my team. And I'm so proud to be working with them and what they've already accomplished. And I'm really excited about what they're going to accomplish in the future.

AMY BRINKLEY: Thank you, Jay, and hello, everyone. You know, I can't even get started here without first just thanking Jay. And I'm sure it's not lost on anyone how important it is to have your commissioner's support with any initiative that you're doing, but especially for recovery.

So for me, in my role at the state, I'm a person in long-term recovery, but to see that transition happen, of including recovery and recovery support services into our vision and mission, was huge. So I just want to publicly say, thank you, Jay, for your ongoing support of recovery, and for being that voice for those of us that are in recovery.

So hello, everybody, and we are so excited to be here. We're excited to talk about what we've been working on. As they said in the bio, I am Amy Brinkley, I'm the Bureau Chief for the Office of Consumer and Family Affairs at DMHA. Primarily, my role involves peer and recovery support services.

And so we've really been evolving over the last two years. And so what we're going to talk about today is how Indiana is collecting and defining recovery data, and how we plan to use that recovery data.

So some of our data sets that we're going to go over today is the recovery support workgroup, and the data says that they are reviewing. And we're going to talk a little bit about the recovery data.

I will tell you, as we jump into the recovery support workgroup initiatives, that I've been at the division now for three and a half years, and the recovery support workgroup was one of the very first things that were put on my plate, and I was supposed to chair this recovery support workgroup.

I walked into my first meeting, there was 10 people. I was late because I couldn't find the room, it was a big state house. I got lost. And they're like there, you know, you go to the head of the table. I'll never forget that moment and the awkwardness.

But some of the early struggles-- we had about 10 people, but everybody was coming with varying interests. And we just, month after month, it seemed like we weren't getting anywhere. And I was getting frustrated. And I was trying to lead this team, and we didn't seem to be getting anywhere.

And Jay's predecessor, I would beg him to let me disband this group. And I'm super happy to say that I'm very glad today that he dug in and refused to let me do that. Because as you'll see today, we've really done some amazing things with that group.

So Erin Quiring is the longest standing member of our recovery support workgroup, so she's been at DMHA much longer than myself, and she's got more of the historical knowledge. So I've actually asked Erin to go ahead and walk us through the process of what the recovery support workgroup does, and how it originated. Erin?

ERIN QUIRING: Thanks, Amy. So yes, the recovery supports workgroup was formed under MHAPAC, which is our advisory council for our federal block grants in early 2012. And that year for the block grant, for the federal block grant, recovery supports was identified as a priority area. And so this workgroup was formed to gather data, and then complete a gap analysis. And that has become the basis for most of our work.

I joined shortly thereafter, but my understanding, Amy, if you want to go to next slide, was that two surveys were created. One was for consumers, we got about 500 responses. And then one was for families, and we got close to 200 responses, exploring recovery supports and asking for feedback on what folks felt like was important, and also what may be missing from their recovery.

And the results were pretty consistent between the two. And you can see them on your screen, personal support network.

AMY BRINKLEY: So I think Erin might have frozen up, so she might be having-- oh, there she is. You're back.

ERIN QUIRING: Can you hear me?

AMY BRINKLEY: Yes.

ERIN QUIRING: What was the last thing you heard?

AMY BRINKLEY: The last thing was personal support networks.

ERIN QUIRING: OK, so I was just going through what the items were-- so personal support, peer support, hobbies and interests, and prevention and wellness, and then safe and affordable housing were identified across the two surveys, the two groups that we gathered data from.

And the group you'll see on the right, those are folks that have been involved in the workgroup from its inception, from other state agencies. We've had community members. And as Amy noted, we've gone through some transitions in composition and finding focus, and we spent the last couple of years reassessing these supports that folks had identified, because enough time had passed. But in the different ways that we surveyed and reached out, they continued to rise to the top, and folks identified them as critical to their recovery.

And you'll also see in purple, we've overlapped them with SAHMSA's dimensions of recovery, which has been an initial additional connection that we've made and have been keeping at the forefront of our work, as well. Want to hit slide, Amy? So do you

Want we're going to dive a little bit here into some of the structure and how we found our footing, and I think it's important, again, as Amy mentioned, we went a lot of different directions. And in the past year or so, we've had some really great folks in the group who've given us a lot of feedback. And so we realized we need some additional support to help us get further in the process of being able to utilize data, and to be able to make recommendations to make sure folks have access [AUDIO OUT].

AMY BRINKLEY: Looks like we might have lost Erin. Oh, there she is.

JAY CHAUDHARY: We lost her at access. There we go.

ERIN QUIRING: You didn't miss much-- access to needed supports, and also fill in any gaps that may exist in access to those supports.

So again, we had that initial task. And we went through membership and leadership changes. We got different members at the table, and so we were going different directions. And of course, folks have different, as Jay mentioned, priority areas, and what they think should be top of the list. And so we wanted to create some of this structure to make sure that we're able to maintain our work, we're all going the same direction, that we're getting accurate and adequate data, and reporting out, as well.

And so having this clear structure has helped keep this work group together, and also helped us engage new members and new partners to help with the process. So we actually engaged an external vendor, Essential Virtual Solutions, to help us with doing a lot of the lift of putting the structure into place. That has been really key.

They helped us establish where we've been. They reviewed and compiled years of historical information. And then identified what would help us move forward to meet our goals.

For example, one of our goals is that we have at least half of the folks on our workgroup be individuals with lived experience. And so they included that in a

survey of our workgroup members, to make sure that we were hitting that goal. And we are.

That same survey and feedback from the workgroup members helped us establish our mission statement that you see on the screen, as well as create subgroups for each recovery support, and identify the need to add a group specifically for data, as well as employment supports is another group that needed focus.

So we currently have seven subgroups that meet monthly, and then the whole group meets quarterly. For report-outs from the subgroups, and any other business that requires the full group-- [AUDIO OUT]

AMY BRINKLEY: It looks like Erin's having some internet issues. There she is.

ERIN QUIRING: Back? OK, EVS has helped us create quite a bit of the structure that we have, and I'm going to go through just a couple of the items that we've put into place here on the next couple of slides.

So one of them is charter forms for each of our subgroups. So it includes a mission for that group, again, to keep people focused and on the same page. The definition of that recovery support, and then [AUDIO OUT] included, as well as what's expected of members, as well as the chair.

And then the groups will use these to track progress. So what data they're going to look at. There's also a space for goals and objectives, and they really create a base for each group to work from, and create a historical trail for future members. And then we're also currently housing that information in teams, as well.

And then, another key piece, again, as we're getting into a phase where we're trying to make recommendations and fill in gaps, is how those decision [AUDIO OUT].

And then the flow chart establishes where recommendations or ideas go-- generally to the whole group. And then depending on what is recommended, it may go to someone in the division, to leadership, to Amy-- it just will depend on what the nature of the recommendation is. And again, just an important piece of establishing structure for how we're going to complete our work moving forward.

So we just split into these subgroups at the end of 2020, and each group is starting to sort through data to begin the recommendation phase. And so we'll talk a little bit more about the specific data that we're looking at, and I'll turn it over to you, Amy, and see if I can work on my connection.

AMY BRINKLEY: Thank you, Erin. So before we jump into the data, I want to say, with this flow chart, and with the charter-- which is really the true north for

the subgroups, and really just the standardization of this entire process-- our hats are off to Becca Segavis, who is our contractor. Because she's really turned this around for us.

So in the past 18 months, we've just completely transformed. We've got additional stakeholders, we've got additional state stakeholders. We've brought on board Medicaid, and Department of Health. And so all of these fantastic changes for the makeup of the recovery support workgroup, and what we're doing with even the data, wouldn't be possible if we hadn't had that additional support. So we are very thankful to our contractor.

So with that being said, the data set briefs that we're going to talk about today-- the top four data set briefs that you're looking at here, which is the Indiana Recovery Council survey, the satisfaction surveys, DARMHA data, and SDOH data, are the specific data sets that our subgroups are reviewing in all of the subgroups.

So every subgroup will be reviewing these data sets. And then we also have some data set briefs that our partners are bringing forward and offering. So we have the Indiana Criminal Justice Institute that has offered six additional data sets that we can review, and maybe ask for more information on if we want. And then Indiana Department of Health has added three.

So those we've listed here is just in process. So as the makeup of our membership grows, as we get new stakeholders on board, they're bringing new data. We've had Department of Corrections offer data. So it's really been beneficial.

And so Ari is actually our chair, our interim chair, for the data subgroup. So Ari, do you want to share for a moment? Because you've really been the one to transform the data-- I mean you created the data set brief. You've really modeled this for us.

AHRASH NASSIRI: Yeah, so Becca was extremely helpful in identifying a lot of the gaps that we had in the recovery support workgroup, and one of those was the data piece and how we communicate with other subgroups. And that was identified as something that could really help move us along and get data-driven decisions faster.

And one of the things that we really discussed was the fact that even with the fact that there was a limited amount of data that we had at the time, versus what we eventually want, it's hard for subgroups that are meeting quarterly, and also monthly, for everyone to remember all the data that's out there. And especially with everything else everyone has on their plate, it's hard to remember the specific data that's available for this project and this initiative.

So one of the things that we discussed was how can we better communicate? And the first piece that we thought was to create data set briefs. And to discuss with everyone what those different data sets should have-- and so

there are several key components identifying who the data set owners are, that way we have someone to contact to ask questions about it. Identifying the context parameters, data periods, and key metrics that are inside of each data set brief.

And then, these are really the first pieces that allow folks to see what is actually involved in each data set. And what those parameters are, what the different fields are. And then the next phase of that is if they have any questions about it, to contact the data set owners, and have discussions with the subgroups, and then make data analysis requests based on what they find they'd like to know more about, or gaps that they see, and data that isn't there but that they've identified they'd like to know more of.

So we're really excited to work with the subgroups. And also expand our data, because it really also identified what gaps we had once we started compiling these and putting them together.

AMY BRINKLEY: Thank you, Ari. Ari's really been the person that's been behind most of that work. So just great job.

So the first thing we're going to look at here is the Indiana Recovery Council survey. So the Indiana Recovery Council is an advisory group for DMHA that consists of 16 consumers in both mental health and substance use recovery. And so this is a first-time survey that was administered to people with mental health and substance use disorder lived experiences.

The Consumer Council came up with the questions. Key considerations-- and I'm going to try to go through this quickly because we have a lot of data to cover and I want to make sure we have plenty of time for discussion, because we really want to hear what everybody else thinks, and get insight and just have a really robust conversation.

So key considerations here is that there was 19 total recovery centered and demographic questions that were included in the survey. Survey was open for approximately four weeks. It was sent out six months into the COVID pandemic, and we had just under 199 people with direct lived experience who responded.

The survey asked respondents demographic questions that identified their gender, race, ethnicity, age group, and the county in which they reside. We also asked questions about length of recovery gaps, and dimensions of recovery that are missing in their daily lives. The lived experience breakout was co-occurring at 50%-- 50% of our people identified as co-occurring. Mental health was 20%, SUD, 18%, and then we had about 11% of people who identified as family members.

So some of the disparities that immediately became clear as we started filtering some of their responses are the similar disparities that we're seeing in other data sets. So for example, when we asked the question about

dimensions of recovery missing from daily lives, when you're looking at the overall number, it looks purposes is our leading gap that's missing in recovery. However, when you break that out by race, home for Black and African-Americans is at 71%, which is significantly larger than our white Caucasian and our overall percentage here at 48%.

Same thing with barriers to treatment and recovery supports-- there's some disparities there to transportation. And I will say that we did define SAHMSA's dimensions of recovery within the survey so that people would know exactly what we're referencing to when we say health, home, community, and purpose.

Social determinants of health-- so we had about 16 pages let me say that again, 16 pages of open-ended responses-- people really wanted us to hear what they were experiencing across the state. So what we did is we took this chart, and we outlined it. So what we have here is health, home, community and purpose, down the length of the paper. And then on the side, we have social determinants of health.

And then we popped the open-ended comments into the buckets where they fit. So granted, we had 152 total comments, but not all of them fit into the SDOH, so we had to bucket some into barrier themes.

So one of the things that I want to say here is that when we look at the SAHMSA's dimensions of recovery, access was the largest issue. So we had 111 people whose open-ended comments fell into access, and landed under that health slot. When we looked at the barrier themes, it was the same thing-- all of those barriers were related to access, quality provider, capacity, insurance costs, wait times. I mean, those were the leading barriers people were experiencing.

And so last thing I'll say about that, and we'll jump over to Erin, is hopefully-- and I'm not going to get into too much of this survey because there's so much we can get into-- but ideally, people who are in recovery have different needs based off of their age, based off of their race, based off of their region, based off of their length of recovery. People in early recovery have different needs than people in long-term recovery. People at 20 have different needs than people at 60.

So those are the kinds of things that this survey will help us to dive deeper into. So as the subgroups are reviewing this, they can ask questions, we can pull and filter and move things around as requested. So that's how that fits into the recovery support workgroup.

And Erin, back to you.

ERIN QUIRING: Hopefully back. I'm going to leave my camera off in the interest of my internet connection. But I am going to talk a little bit about what we call the MHSIP and the YSSF-- and the formal names are there on your

screen. These are consumer satisfaction surveys that we've done for many years as part of our federal reporting requirements, both with adults and families of youth.

They're standardized surveys that primarily focused on treatment and treatment outcomes. But we also have some room to add questions and additional requests for information to the standardized survey. And for the recovery supports, we've gone through a couple of iterations, again, in the trying to track and figure out if the identified recovery supports are still important to folks, and then how useful they are, and how providers are connecting folks with recovery supports.

And so, it's a great opportunity because we get about 6,000 to 7,000 adult responses each year, and we get about 5,000 for the family surveys. And traditionally, this is something we've done on paper, but due to COVID, we've had to move it online a little faster than anticipated.

And hope to be able to reach out to folks who missed the survey window at their provider. Because right now, again, with the paper, it traditionally is done in a three-week window at treatment providers' locations. And so it's certainly a convenient sample-- it tends to skew positive because it's folks that are walking through the door and meeting with their treatment provider, in theory, semi-regularly.

Amy, do you want do do next slide?

So just to give you an idea-- I pulled a couple of the questions, the bulleted questions at the top are a couple of the questions that are part of the standardized survey for adults. So encouraging folks to engage in consumer-run programs, being happy with friendships, having folks in your life who will listen and understand certainly can overlap with the identified recovery supports.

And then the figure below shows the responses to one of the specific questions we asked about access to peer support. And this is state-wide results, and we have an opportunity, certainly, to dive a little bit deeper by county, by treatment provider. And to break down, we collect several categories of demographic information that we could drill down a little bit further in the data, according to what group may be interested in and seeing.

Next slide. And then another huge data source that we have we call DARMHA. And again, the words are on the screen-- we like to use acronyms. But it is a system that we use for our funded treatment providers to submit information to DMHA.

It's a really wide range of data. But we do have it accessible to the county and the zip code level, as well as multiple demographic categories that we can review. And there's items in there, like national outcome measures, that will

likely be useful to our work groups, like residential status and employment status.

But then, one of the big chunks of data that we're looking at with the workgroups is the CANS and the ANSA. And these are assessments that we've had and used with our contracted providers for over 10 years. And they have a range of items designed to assess individual's needs and strengths. And they're repeated roughly every six months to track progress.

And all of that information goes into DARMHA, and there's several items that overlap directly with the recovery supports that we've been looking at. Slide.

So we have a partnership with the IU School of Social Work, and Dr. Betty Walton and her team have done a lot of work to develop reports that help us see outcomes. So what you see on your screen is an example of a report that's already developed that shows strengths on your left, and we want to see those numbers go up, indicating that folks are developing usable strengths.

And then on the right are needs. And we want, of course, see those go down, indicating that those needs are getting resolved.

And this is a look at it statewide data, but you can see there's several items that overlap with recovery supports, family strength, social connectedness, job history, employment. And so they overlap almost directly with those recovery supports.

And the team is working on some newer reports that will show a little more nuance. You'll notice these numbers showing the change are pretty small. But that's because they rely on bigger change-- that needs are completely resolved, or that someone has developed a strength to the point of it being usable, and doesn't get at some of the progress that folks might be making.

Next slide, Amy?

AMY BRINKLEY: I'll jump in here quickly, Erin, if that's OK. I just want to add that, what this will do for the recovery support workgroup initiatives is this is going to be extremely beneficial for us to monitor outcomes. So ideally, as the recovery support workgroup makes recommendations-- whether they're policy, funding, legislative-related recommendations, we can actually then monitor.

So if we notice a huge increase, or a need increase, we can monitor and hopefully gauge what caused that. And be able to see if we're making a difference. When we saw this, when Erin shared this with us, we were very excited.

ERIN QUIRING: Yeah, and so there are, I mean, again, based on that, looking at those reports and the small amount of change you see there, the

team from IU has also been working on some newer reports that show not only resolved needs, but also any level of improvement. So this is the employment item specifically-- and statewide.

And so at the time of the report, 41% of folks roughly had employment identified as a need. And you can see the middle bar is clinical progress. So these folks-- they haven't resolved the need, but they've at least made some progress to address their needs, as far as employment. So it shows an improvement of 5.66%, whereas on the previous slide, the improvement on the employment item was 0.1%.

So that nuance and progress shows a little bit more what's going on with the individual. And if we're seeing any improvement, versus it being all the way resolved. And again, we do have the ability to narrow down to county with a lot of these reports. We can also look at evidence-based practices, as well as the demographics that are collected, like gender, and race, and that sort of thing, as well.

I think with that, I'll turn it to Ari.

AMY BRINKLEY: OK.

AHRASH NASSIRI: Thanks, Erin. So I'm going to cover these social determinants of health data that we've collected for the recovery support workgroup. And I'm going to share my screen now.

No, got to click the share button to share the screen.

All right, so what we've done is we were really excited at the recovery support workgroup when we heard about something that FSSA, the Family Social Services Administration was doing as a whole. And that was, they started to put together a social determinant of health questionnaire as far back as August 2018.

And this questionnaire has 10 questions, from not having enough money for food in the last 12 months-- oh, it just want away-- from not having enough money for food in the last 12 months, to not engage in regular exercise. And what they did is they asked all respondents that were looking for health coverage, SNAP or TANIF online, to answer this questionnaire.

And the questionnaire did not affect coverage in any way, shape, or form. And the questionnaire was asked for the head of household of everyone applying for coverage. So there is a high possibility that it represents more than one individual for every respondent.

And then, as they collected these, they've been displaying it in what is called the Hoosier Health and Well-being Atlas. And when we saw this, we were really excited because of two things. One, it meant the data was published and available for use. And two, this atlas is a Tableau dashboard, which

means that as you click on it, it'll change. And the demographics of age, education, gender, marital status, and ethnicity will also change.

And Amy immediately was like, hey, Ari, this is amazing. How can we get this over to be usable for the recovery support workgroup? And so we started working on doing a connection with Medicaid claims.

MODERATOR: Ari, I don't mean to interrupt you, I'm sorry. But we had a request if you could maybe zoom in your screen a little bit so folks could get a look at the graphics and stuff.

AHRASH NASSIRI: Of course. So this is the health and well-being-- no, it's a little too close, probably. Health and Well-being Atlas. So here you can see, as you click on a county, the number of respondents, total assessments, as well as the numbers that they answered for yes are going to change for every one of these other containers within the dashboard.

And so what we wanted to do was take a look at this population, the amount of survey respondents that were out there, and connect it with those who had previous coverage, and that had a diagnosis and a paid claim for SMI or SUD within the year previous to these survey respondents.

And what we were able to do was to create a report that is aggregated, and doesn't have any private information on it, by just looking at the counts of those that matched. And we were able to match around 5,000 folks total that had an SMI or SUD diagnosis in the year previous to answering the social determinants of health questionnaire.

And what we also did is we used our previous survey that highlighted social determinants of health areas that we wanted to focus on, to focus on specific questions. And those questions that we focused on were utilities shut-off in the last 12 months, fear of not having stable housing in the next two months, problems getting child care, costs for transportation preventing seeing a doctor in the last 12 months, fear of being hurt in the home, and not engaging in regular exercise.

And what we've done is shared this with the subgroups. And I'm going to zoom in again so everyone can see it. And put it on a Tableau dashboard, that way the subgroups are able to access it and utilize this dashboard to take a look at trends in different counties. This is a heat map that shows the amount of respondents for yes for different questions.

And you can click on a county, and then it's going to change the other containers, as well. I just made that--

Then as you see, the other containers of race, age group, and gender, all changed, as well. And what we've done is taken a look at this, and this really helps influence our decisions, as far as what we need to do next.

So we're expanding this so that we can have an SMI, SUD, SMI/SUD co-occurring, and a neither filter, so we can take a look at how those trends compare across those different subgroups. As well as expanded the capture of those with those conditions to five years instead of one, to capture those who may have lost coverage, been incarcerated, or had other issues during those five years.

So we're very excited to see where this leads us next, and move forward from there. So I'm going to--

AMY BRINKLEY: Ari, don't stop sharing for a second, if that's OK.

So the only thing that I would add here is that this is very exciting for the workgroup, and the SEOH questions, they were about 10 deep. But what we recognized early on was that we wouldn't need all questions. So we just didn't want to pull data that would maybe confuse our subgroups, or it just wasn't necessary.

So Ari's really been helpful in helping us make the appropriate data pools based off of just what we needed. And the other thing to mention here, too, I think, Ari, is that the 10 questions and the larger data pool is actually comparative that we can then use in the future, because we're extrapolating the SMI and SUD populations. But we can also then do some comparative analysis to guide some of our recommendations.

So we've been just super excited about this. And the questions that we pulled were consumer identified gaps. So we didn't just pull what we thought was important, these were things that consumers in Indiana identified as needs. And so that's what we've just been very intentional about focusing on, to make it consumer-centric. So we're super excited.

AHRASH NASSIRI: Thank you, Amy. And just for everyone's knowledge, this is what a data set brief would look like. And this is for the social determinants of health connection. And as I said, pretty much everything that I stated is put in this brief section, which is a couple of links to the data, itself.

And then future work that I stated we're having done is in this section. Key metrics for the subgroups that they want to put in, and takeaways. And then how to contact folks is in there.

So I'm going to stop sharing now. Thanks so much, Amy.

AMY BRINKLEY: Thank you, Ari. And every subgroup gets one of those data set briefs. So everybody's getting the same data set brief, but each subgroup can pull-- let me find the right one-- but each subgroup can pull additional data or ask questions.

Can everybody see that?

OK, so the next thing-- I think we're right on time. This is awesome, you guys, usually we go over.

So the next thing we're going to talk about is the recovery data platform. Some of you guys may have heard of the recovery data platform, but this is a new recovery data set that we started about eight-- I want to say eight or nine months ago. And so this is a cloud-based recovery platform that's house within Salesforce.

We have a two-year contract with Faces and Voices of Recovery. We purchased 200 licenses. The licenses will be utilized by peers across the state of Indiana. Originally, we started with two super users, one with a Division of Mental Health and Addiction, and one sits with the governor's office.

So we recognize that we're very lucky to have the governor's office and the governor's support in our work, as well as our state commissioner. Our current partners are the regional recovery hubs, which involves 16-plus organizations. And I will say that we've increased that to 20 as of today.

And then each organization has peer staff between one and 10 per organization. However, some of the regional recovery have the RCOs, is what we call them, the recovery community organizations. Some of them are actually partnered or additions to local treatment providers-- community mental health centers. So when you look in an org chart, they might have hundreds of staff. But the RCO, itself, usually has one to 10 peer staff.

And then we have some pilot sites. So we have some pilot sites testing out the RDP for flexibility within different settings, like recovery, residential, residences, recovery residences, a youth-- the landing is like a youth recovery community organization. So working with youth, working with mental health, as well as SUD.

So we want to gauge what we can possibly do with RDP, in case we want to use it for more than what it was originally intended. The recovery data platform-- the things that we're using it for right now mostly is general interactions-- intakes, referrals, and the recovery management plan. One of the biggest things that we were excited about when we first learned of the recovery data platform was the vital signs.

And so the recovery vital signs, you know, when someone goes to the-- and this is how they explained it to us, and it was just this huge selling point-- when you go to a primary care doctor, or the dentist, or the emergency room, or your pediatrician, they always check your vitals. And so recovery vital signs, these are the same, and that is just a quick snapshot of where that person's at.

And if your blood pressure is too high, it rings an alarm that there's something wrong. And so the recovery vital signs is the same thing. So there are scales that are used to measure where people are at within their recovery.

So a couple of them that we're going to talk about-- the lifestyle scale is one. And so ideally, the lifestyle scale will be captured once, just to get a snapshot of potential barriers related to housing, relationships, mental health, education, or criminal past. The next one, you guys have probably heard of, is the BARC 10-- or the brief addiction recovery capital scale. And this is captured once a month, or every three months to gauge recovery capital growth or digression.

I'm using one question from each of the 10 recovery capital scale domains. So it's just a shorter version of the recovery capital scale.

Important to note here, too, is that the 10 domains actually have some overlap with social determinants of health. So once we get the regional recovery hubs capturing this data on a regular basis, we're going to have a more SEOH data here, as well.

Now, we strongly encouraged our RCOs to be capturing this on a regular basis. But there are no mandates, we don't have it in contract yet. And really right now, we're just working through the basics of understanding how to do an intake, and how to navigate the system and how to pull the appropriate reports. So we're not really pushing too much on the vital signs, but we do have some RCOs that are ahead of the rest and are capturing this data on a regular basis.

So the next one I want to talk about is the engagement scale. So this is actually three scales in one, and it's potentially one of the most important vital signs that we hope to have captured weekly. So the outcome rating scale-- we know that the opposite of addiction is connection. So here, we're capturing how the person is doing in their relationships, and connecting to their support system in the community.

The cravings rating scale is only two questions, but it's very direct and to the point. And helps us check on where that person has been with their cravings, and over time that information will tell a story. I'm in recovery now, by the grace of God, for 12 years. And I can tell you, early recovery was tough.

And so I truly believe that that early recovery story will tell a sign-- will tell us some things. The relationships rating scale is also very important. It's going to help us understand the unique relationship between the peer and the recovery. And these are all self-reported scales, so the recovery is the one that's entering this data.

It's going to help us see how peers are connecting, or not connecting, to the recovery. It'll be a great tool for our peer supervisors to be used during supervision. How are things going? You know, your recovery is not really feeling very connected to you, is there anything we can do to help?

And then the other thing, too, is that if you have a recovery and a peer who's just not connecting, you can try to move that person with a new peer. Or

maybe it's the peer-- maybe that peer is not connecting well and needs additional support, themselves. So it's just a way to monitor and measure that.

So here we have some visuals. What I want to say here is that the recording within the RDP actually allows us to pull out any of the scales in one chart, or overlapping, for comparative purposes. So there is a lot of preventative opportunities here.

For example, the outcome rating scale and the cravings rating scale can potentially predict a relapse. And the reason I say that is because if the outcome rating scale is capturing how that person-- how the recovery is connecting to their community, and how they're feeling about life in general overall, and the cravings rating scale is measuring cravings, what we'll know, what we should notice, what the data should tell us, is that as that person's connections dip and their cravings ratings rise, if there's a relapse, you'll have the vital signs of where they were at in that moment.

Assuming, number one, that the data was entered, and the questions were asked. And two, that the person was being honest. So there's a lot of other variables that we recognize that go into this.

But ideally, if I'm working with someone for a year, and I'm capturing this data every week, and the person relapses three times in the previous year, if I go back and review where their vital signs have been, ideally at some point, we should be able to get in front of that, and there's some intervention opportunity here. If it's used, and if the person is honest.

So the other thing I mentioned here, too, is that as a person in recovery, especially early recovery, and no matter where you're at, you have some bad days. So this is a great way to be able to visually see your progress.

So if I'm working with someone and they're just having a really bad day, their mom just died, their boyfriend broke up with them, and their car wouldn't start this morning. You know, it's a terrible day, but let me show you where you've been, because I've been super impressed about your progress. And so we have a way to visually give that person an idea that, it's a tough day, there's no reason to go back, because you've really made progress, and it's going to get better. And that's important for someone that's in recovery.

I think the other exciting thing for me is that the possibility to see this on the individual level, but then also on the aggregate level. So working at the state, you know, I can actually pull this information and get a snapshot on any given day in real time, Indiana's recovery vital signs for the recovery community-- which is really cool for me.

And we know that people in recovery, what I love about the regional recovery hubs is that people in recovery-- it's community-centered. And so our RCOs are community centers. So there's an ongoing relationship. So as long as you

have a peer, we can potentially be capturing this data, and it's not tied to treatment that ends at a certain date or time, if that makes sense.

So the last slide here-- to date, we have 20 organizations utilizing the recovery data platform. That's actually 24, because we have a four pilot sites. We've issued over 100 licenses now. And I checked yesterday, we have over 900 participants entered into the RDP. And they're just plugging away.

So last month-- so our regional recovery hub initiative started early COVID days, because we were recognizing that people weren't getting access to the supports that they needed, and we recognized that peers can be an intermediary, and they can help people navigate barriers within their local communities.

So the regional recovery hub started back in April. Last month alone, 1,600 people were served in direct peer support. 1,100 were served through groups. And to date, since April, we've served 14,000 people, and had 2,600 referrals.

And the last thing I want to say about the region recovery hubs is that as our recovery support workgroup moves through reviewing data sets and making recommendations, if there are funding needs or policy changes that are based by region, we now have locally placed recovery community organizations that could potentially implement or pilot things, if we get to that point.

So we're not married to any one way of doing this, yet. We're still kind of working through-- it's just been an evolving process. Our data sets have evolved, our focuses have evolved. The only thing that we haven't moved from is the person-centered focus on gaps.

So we've just been moving along. And super excited to be here and to be where we're at. And we'd really like to hear from everybody else thoughts, insights, questions. So I'll go ahead and give it back to our host for the questions.

MODERATOR: Wonderful. Thank you, this has been an incredibly informative presentation. Lots and lots of comments about how everything is great, and they're very excited to get this information.

I just have a couple-- sorry, I wanted just quick grabs this one before it goes away-- the first one is, can you speak to the challenges of collecting data for persons and organizations that fall under the umbrella of anonymity?

AMY BRINKLEY: Can you read that one more time?

MODERATOR: Sure, can you speak to the challenges of collecting data for persons and organizations that fall under the umbrella of anonymity?

AMY BRINKLEY: So we haven't-- there is a challenge there, and you're right. And so we haven't-- I'm not going to say that-- it is a challenge. I don't even

know what else to say, because if the person chooses to remain anonymous, there's no way to capture that data.

So what we have done, though, is we've gone directly to our community-based organizations. We've used our grassroots organizations and advocacy groups, like NAMI, Mental Health America, Key Consumer, and we've used our peer-based recovery community organizations to help us infiltrate the recovery community.

So when you look at the Indiana Recovery Council survey for example, consumers created the survey. The survey went out-- they did not go through our treatment centers, they did not go through our community mental health centers, they did not go through any kind of clinical or treatment setting, whatsoever. It went straight to the community. And that's about as close as we can get to it.

Because we recognize that there are people that want to remain anonymous, and that's OK. I think the reason we had such a wide response for the Indiana Recovery Council survey is because we were asking barriers-- specific questions. And if there's anything that people want, is they want the state to know that there's barriers, and that change needs to happen.

And so that did tend to bring out a significant response there.

MODERATOR: This one says, hi, amazing Indiana staff. I'm wondering how much basic education on data, data collection, data reports, et cetera, you had to do with the subgroup members, and how did you do that?

AMY BRINKLEY: I'm going to let Ari answer that.

AHRASH NASSIRI: To be honest, not a ton for us, particularly. Luckily, FSSA had started a data literacy program probably six months-- it started in implementation prior to our work with data set briefs, and other data work that we're doing. So luckily, everyone internal to FSSA had availability to join that data literacy.

But I think the data set briefs were a big component of that, too. The whole point of those data set briefs is, can you explain the data in a way that makes sense to folks that may not use data all the time? And they're also meant to be a point for a conversation. I think the big thing is letting people understand what is in the data, what parameters are there, letting them have access and hands-on with that data, and then ask questions as they need.

And I think the subgroups are also composed of a diverse group of people in each subgroup that have different levels of experience interpreting data. And I think that's also a big help. So we didn't really have to do a ton of work, as far as educating folks on data. But I think having an open communication and conversation really helps.

ERIN QUIRING: That's also part of why that data group was added, to being able to house the information, and then as requests come in, help folks streamline and tweak as needed, based on what's available in the data set. So that folks aren't just up trying to figure it out on their own-- they have that group and experts on those data sets available to them.

AMY BRINKLEY: And that's Ari's crowning glory, because he really helped streamline that whole process, and simplified it for folks. So that's--

AHRASH NASSIRI: Amy likes to try and make me blush.

MODERATOR: Well, when you do fantastic work, it's easy to do that. We have time-- I just want to be respectful that it is at the end of our hour. So we have one question that has been asked several times, but if we're not able to get to the questions, or you're not able to stay on, we will get them answered in writing, and they will go up on the website with the recording and a copy of the slides.

So the last question is, would it be possible to get a copy of the survey questions?

AMY BRINKLEY: Which survey questions? The social determinants of health?

MODERATOR: It was asked multiple times throughout the presentations, but I think it was referring to-- and possibly different parts of the survey or the different surveys, generally.

AMY BRINKLEY: So I think that, I don't mind putting my email in the chat. And if you have specific requests, I can help guide and direct that. And Ari, perhaps we can share, and Erin, too, because she's got some of them. Because each data set is owned and house with different people. So it's hard.

I mean, the data set briefs, Ari's got the collection, I've got the collection, Erin's got the collection. So it's just a matter of pulling them from each of the data set briefs.

MODERATOR: And I really, really need to apologize, we are not done. We still have time for questions.

AMY BRINKLEY: I was thinking that-- I thought we had--

[INTERPOSING VOICES]

MODERATOR: I'm sorry, I apologize to everyone who I panicked.

The next question is, how do you get so many people to respond? Are the surveys going directly to consumers, or are you utilizing other agencies to collect the data at the point of service?

AHRASH NASSIRI: For the social determinants of health data, the questionnaire was a part of getting health SNAP or TANIF coverage and part of that application. And it was just part of the online process. So it was just 10 simple questions, and it was made clear to the respondents that it doesn't affect your coverage in any way, in that these questions will not be identifiable to anyone outside of the state.

And in fact, the state takes the data very seriously. So if there's a count of folks that is less than 20 for a specific question in a county, that's not represented. And so it was just part of the online application for those coverage pieces. So I think that was a major component of getting those respondents.

ERIN QUIRING: And I can tell you for the satisfaction surveys that we do, where we get 6,000 to 7,000 responses back, we do actually have a third-party vendor who works with our treatment providers to get those surveys out. And we give them a confidence interval-- so a number of surveys that they need to reach their confidence interval.

And that has been pretty effective in them reaching for that level, or number of surveys that they're required to put out and get back from folks.

AMY BRINKLEY: And to be fair, like with the Indiana Recovery Council survey, we didn't have a lot. I mean, we had 200 responses-- 16 pages of open-ended comments, but that goes back to the earlier question about people who want to remain anonymous. We tried to go directly to people that are maybe not receiving services, or had barriers to even accessing services. But it's a struggle.

MODERATOR: Great, thank you. Would you be able to share an example of the data metric sheet that you use?

AHRASH NASSIRI: You mean the data briefs? The data set briefs?

MODERATOR: The question-- it's not that specific. The question just said, would you be able to share an example of the data metrics sheet that you use. Oh, yes, a data brief sheet, yes.

AHRASH NASSIRI: Yes, I have a blank copy. I'd be glad to share it with anyone. Just send me an email.

MODERATOR: OK. The next question is, how did the RCOs recruit for peer recovery support specialists? And do they have a minimum education experience, or clean time, et cetera?

AMY BRINKLEY: So I think the easiest way to answer that is that we, at the state, we partnered with our state level recovery community organization. And that is the NEI Addictions Issues Coalition, which is a statewide advocacy

group. And so I think Heather might even be on here, so Heather, feel free to add anything in the chat that I may bomb here.

But each of the RCOs are recruiting, marketing, and managing at different levels. So like we have some that are just starting up, we have some that have been in existence for years, we have some that are partnered with our community mental health centers, so have a solid support system. We have some that are just really grassroots. And so all of those, they're doing that at all different levels.

Now, when it comes to the peer requirements, we have to peer support credentialing agencies in the state-- we have our peer recovery coaches, and then we have our certified recovery specialists. And each of those credentialing agencies have different requirements. I believe one year is the minimum length of wellness or recovery to even get credentialed, but to be a peer at the RCOs, the person has to have a peer credential for sure.

And then, Heather, if you're still here, she would be the person to chat with about that if you had other questions. And she could put her email-- I don't want to throw her under the bus-- but she can always put her email. And then I see Beth here, too, so she's one of our RCOs that could help answer some questions.

MODERATOR: Here she is.

AMY BRINKLEY: Email Heather. She's our overseeing person for all of the RCOs right now.

MODERATOR: Thank you, Heather. What are the extending challenges of including family members into this peer process, and are there any legal requirements on the client's personal information, or restrictions?

AMY BRINKLEY: I'm going to be honest, I don't know that I fully understand that question.

MODERATOR: OK, so--

AMY BRINKLEY: Can you restate it?

MODERATOR: I can-- what are the extending challenges of including family members into the peer process, and are there any legal requirements on the client's personal information, or other restrictions?

AMY BRINKLEY: So just hearing that question, I have so many questions. So I don't know if that question is meant for the RCOs, and maybe that referral process. But if that's the case, a release of information would need to be signed. I mean, the RCOs, they track general interactions-- so if they run into a mom, sister, brother, husband, grandparent who's asking for supports for their child or family member, the hubs will make a connection.

But if the person is not engaging, and the person doesn't want to work with them, that's the extent of it. It doesn't go any further. And they don't get entered in the system.

Because the recovery data platform, as well as our different data is being collected through these efforts. There has to be more than three meetings with the person receiving services before any intake is completed. If that makes sense.

MODERATOR: Yes, and Christina suggested that maybe it's relating to when the head of household answer survey questions about peer supports.

AHRASH NASSIRI: Yes, no, there's no legal ramifications. All the data that's collected is de-identified for the most part, except for what's held within the enterprise data warehouse, which is where FSSA houses all of our Medicaid claims, and other secure data. And what's released is a fragmented piece of that that's only in the aggregate level.

And that's made aware to the head of households, that none of the data is identifiable, or will be used to identify them in any way, shape, or form, and always in aggregate. And in order to use that data set, we had to explain how we're going to use it, how it's going to be published.

So no, there's no ramifications. It's part of getting coverage is answering that questionnaire.

MODERATOR: Thank you. And that leads into the next question that we have. Is the data warehoused on your site?

AHRASH NASSIRI: I mean, we're all at home now, so not technically. But the enterprise data warehouse is internal to FSSA. And that is a major resource that we've utilized, and that's where all Medicaid claims and other data is housed. But it is an internal one.

And the social determinants of health questionnaire was a task that was a huge lift that the executives at FSSA-- Dr. Sullivan and her social determinants of health team, really drove. And it was years in the making. And just a monumental shift, both in data capture, and what we focus on, as well, when we look at areas to improve health status of the population.

MODERATOR: Thank you. The next question is, are you working with researchers to publish these findings?

AHRASH NASSIRI: A great question. I don't think there are any plans right now for a white paper on any of the data that we're doing, but Amy?

AMY BRINKLEY: So no, I don't think we're quite there yet. We may at some point in the future. We probably will, actually.

One thing that we have done, that we haven't really talked about, is we have the management performance hub. And Ari shared this in a lot of our other presentations, but the governor had actually signed an executive order to create the management performance hub, which is a data warehouse-- and Ari, you might have actually already said that.

But we have access to all of that data. And so that's where the data literacy trainings were coming from, and the webinars, and all of that is kind of originating out of the management performance hub, per that executive order.

And so what we are doing is trying to engage with the MPH staff to get them on board with what we're doing, so that we, number one, have access to that data, and number two, so they, as the experts, can kind of guide us and direct us on what to capture, or how to capture it.

And we'll see where it goes. I'm sure we'll end up doing a white paper at some point, but we're just not quite there yet.

MODERATOR: The next question is, is the framework aligned with local, state, and federal requirements for data security?

AHRASH NASSIRI: Yeah, data security is pretty serious around here. And I'm not going to break it in any way, shape, or form. So yeah, we meet all the requirements for data security. The biggest way we are able to do that is just to ensure that what we release is aggregated only, and that starts with the data analysis and what you're looking at.

None of the data that has been displayed is even in the output form from the data analysis has any kind of identifiable information. It's purely counts of that match population of those two data sets, and there's no way to identify individuals. But yes, we follow the security guidelines.

AMY BRINKLEY: Yeah, the SEOH data was already published. And then the NPH data that we have access to has all been de-identified.

MODERATOR: Great. The next question is, can the public or leadership organizations have access to this collected data?

AMY BRINKLEY: So we haven't-- I don't know that we're quite there, yet. So what we're doing with the data now is the subgroups are moving through the recommendation phase. So we're still working with Becca Segavis at EVS, and once we get through the recommendation phase, once our subgroups get through reviewing the data, making the recommendations, and we get those final reports, we're more than happy to share that.

Now, when it comes to the actual data, we just have some more things that we have to work through. Now the SDOH data, the all-inclusive data, that's already published. And I think somebody shared that in the chat earlier-- I could be wrong. But that's already published, so that's already out there.

But all of the other data, we're still in process. So at some point, it will be available. But just not quite yet.

MODERATOR: Great. And this one kind of leads into that, but can the public-- no, what kinds of registered access is required, to have access?

AHRASH NASSIRI: It depends on what you're asking about. So as far as access into the data, that's kept pretty secure, and at least privilege is something that we follow very closely at FSSA. For me, previously, I was a data analyst before I became behavioral health integration, and so that was one of the ways-- I just had a lot of connections with folks over at the EEW. And I do have access into the protected zone, and could fiddle around with Tableau dashboards, and visualize the data for us.

But we followed the protocols for who is supposed to be going into the EDW's medical claims information. And the social determinants of health survey respondents, all that is done by data analysis requests, so that only the data analysts with registered access to those different tables and servers within the warehouse are accessing them.

AUDIENCE: Amy, would you allow me please to just quickly chime in? Because I think this is just awesome. I hate reinventing the wheel. And what you guys are doing is collecting such great data that can be used across borderlines. We spend too much money, too much time, trying to reinvent the wheel, when what you guys are doing is just astronomical. It is awesome.

So whatever you're doing, keep doing it. It's just that I'm truly concerned about certain individuals having access, because they twisted data to their own-- well, I want to be careful saying this, but it makes all the great work you're doing seem useless.

So I'm very, very cautiously optimistic that I know it's going to work, because I'm listening here and I'm falling off my chair with what you're doing, and we've just got to have those safeguards in place so that not just anybody can get it. Because if you're working on the public's behalf, and somebody did the grunt work for you, gosh, and give you the credit for it. But gosh, it makes life so freaking simple.

And I use the analogy that our families, our loved ones, just don't live in one state or one community. So we need that information. You guys are awesome.

AHRASH NASSIRI: Thanks, Lonnie.

AMY BRINKLEY: Yeah, thank you so much Lonnie. I think that's one of the things that we've been excited, through this process, as it's evolved, is the ability to break down barriers and silos. And so that was what we kept just bumping our head up against in the beginning, is everybody was coming with competing interest.

And so we all wanted the same thing-- we wanted people to have access to the supports that they need, but everybody was working in individual silos-- housing, employment. I mean, one of the most beautiful things is being able to bring everybody-- we broke up into subgroups, so they're meeting monthly doing their targeted focus, everybody self-selecting into their subgroups.

But then during our quarterly meetings, we have those report-outs for everybody collectively. So we have all of them in the same room talking-- they're all living at the same data sets, individually, but capturing what they need, making recommendations based off of their focus. But then we meet collectively-- connections are happening.

And people are communicating across state agencies, and across local and state-wide partners. One of the biggest things that happened at our last quarterly meeting is that we had somebody from the Department of Workforce Development who was running up on a deadline, and had thousands of licenses that she needed to get out the door immediately. And people just started making connections.

She's said, I have to get these done by December or we lose them. And I mean, hands just started raising, and so many connections were made. And now we don't lose those licenses.

So that's just one example of the potential partnership of just having this open platform for communication across agencies. So it's really awesome to see. So thank you, Lonnie.

AHRASH NASSIRI: Absolutely. And I've got to say, as much as the data is interesting, and it's great to have and make those connections, I think the work that the recovery support workgroup, and especially Amy and Erin and Becca have done to really drive it, is more impactful overall.

Because you can have the data, but if you don't have the right folks at the table to take a look at it, to drive it, and to break down those silos of communication, you're only going to get so far. So I think that is probably one of my biggest takeaways.

And the other thing, too, is, whenever you look at data, you walk away with more questions than when you walked in with. So having the right folks at the table, having a conversation, actually, and not having the silos, I think that is one of the biggest takeaways of something that was really, really productive out of the whole experience, and probably the biggest takeaway that I've had with the recovery support workgroup, and the work that I've seen Amy and Erin do. It's been amazing.

Oh, Lynn, I have a good friend up in Nanaimo, and that's awesome to hear. Because I always thought-- I was jealous of Canada's data collection.

AMY BRINKLEY: I would say to Ari, based off of everything that you just shared, we have three of our team members here. But we have some other core members of the RSW that aren't here. So like Cameron Drury is our chair for the peer support workgroup. We have Jenna War who's leading our housing subgroup.

And then we have-- who else? Kelsey Lineville who's leading the employment subgroup. So we have other DMHA staff that are actually helping with this initiative. It's just the core people around the data, I think, is who we have here today.

MODERATOR: Great, that was the end of our questions. And I don't know if you're able to see the chat, but the response to this has been phenomenal. Everyone is thrilled. You're doing amazing work.

And so I want-- a couple of things just quickly is that the recording, the PowerPoint, and any other resources will be available on the Great Lakes ATTC and the Great Lakes PTTC web pages in the Products section. We'll send you a link for those. I know it's been put in the chat a couple of times.

That usually takes us about a week to get it all edited and up. So again, if you have any questions, we also have contact information. So I just want to, again, thank everyone from DMHA for all of your amazing work and your time. And everyone who is on the webinar today, for their time.

So thank you, everyone. And we appreciate it.

AMY BRINKLEY: Thank you.

AUDIENCE: Thank you.

AHRASH NASSIRI: Thanks, everyone.