Emergency Room Enhancement Community Collaborative Survey

May 2018 - Results from ERE Year 5

EMERGENCY ROOM
ENHANCEMENT
Improving Access to Behavioral Health Care

UMSL | MIMH
Missouri Institute of Mental Health

MISSOURI COALITION
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ERE Community Collaborative Survey

The Missouri Institute of Mental Health (MIMH) conducts an annual process evaluation of the Emergency Room Enhancement (ERE) project examining the level of collaboration among partners within each of the seven participating ERE regions as reported by the community collaborators. A central aim of the ERE project is to improve the coordination of care for individuals in need of services for psychiatric symptoms and/or substance use disorders. Collaboration among stakeholders such as law enforcement officers, emergency room staff, Community Mental Health Center (CMHC) staff, substance use treatment providers, and other community service staff is critical to achieve this aim and provide services in an efficient and cost-effective manner.

Prospective participants are invited via email to complete an anonymous web-based survey assessing providers' impressions of how ERE is working and the nature of collaboration among their regional partners - including areas of strength and room for growth for the ERE project. Areas of focus for the survey include:

I. Participant Characteristics
II. Provider Services and Responsibilities
III. Project Communication, Familiarity, and Clarity
IV. Interagency Collaboration and Working Relationships
V. Program Implementation: Strengths, Weakness, Improving in the Future
VI. Impact of ERE on Providers and Clients: Highlights, Limitations, and Success Stories
VII. Overall Summary and Next Steps

In addition to quantitative rating scales, the 2018 ERE Community Collaborative Survey included qualitative responses to improve our understanding of the strengths and weaknesses of the ERE implementation. Findings from the Year 5 survey are presented in this report.

I. Participant Characteristics

A total of 376 individuals were identified to participate in the 2018 survey with an overall rate of survey response at 31.9% (n = 120). Table 1 displays the number of surveys completed by region and by type of provider setting. As respondents represent less than a third of the providers that were sent the survey, the sample may not be fully representative and generalizability of the findings is limited. Future surveys will attempt to ensure a higher rate of participation.

Table 1. Collaborative Survey Responses by Region and Provider Setting

Site	Completed (% of all contacted)	CMHC	Hospital	Law Enforcement	SSA/ Div. of DD	SUD Program	Primary Care	Other
		n = 35	n = 30	n = 15	n = 7	n = 5	n = 4	n = 20
	n(%)	%	%	%	%	%	%	%
Columbia	**6 (33%)**	0%	17%	0%	33%	17%	0%	33%
Kirksville/ Hannibal	**35 (37%)**	14%	14%	20%	11%	3%	3%	34%
KC Metro	**25 (24%)**	60%	32%	8%	0%	0%	0%	0%
Poplar Bluff	**16 (25%)**	19%	25%	25%	6%	0%	6%	19%
Rolla	**1 (14%)**	0%	100%	0%	0%	0%	0%	0%
Springfield	**3 (18%)**	0%	0%	67%	0%	0%	33%	0%
Eastern Region/STL	**30 (42%)**	40%	37%	0%	0%	10%	3%	10%
Total	**116 (31%)**	**30%**	**26%**	**13%**	**6%**	**4%**	**3%**	**17%**

Note: *116= number who indicated their region. Four respondents did not indicate region and are therefore not counted in this table; CMHC = Community Mental Health Center; SSA = Social Service Agency; DD = Developmental Disabilities; SUD = Substance Use Disorder; Other provider settings include crisis centers, school/university, government (i.e. public health department, public defender's office), and mental health education and advocacy agency

II. Provider Services and ERE Related Responsibilities

To examine the breadth and scope of services available within the ERE continuum of care, participants were asked to report on the primary service(s) offered at their agency, their primary ERE related responsibilities, and additional services offered by their agency. As can be seen in Tables 2 – 4 below, respondents came from a variety of collaborative sites offering a wide range of specific behavioral health and substance use disorder services. Respondents identified a heterogeneous list of individual job responsibilities within their agencies. These data point to the multidisciplinary nature of participating collaborators and the breadth of service options offered, reflecting the mission and scope of the ERE program.

Table 2. Primary Service Offered at Participants' Agency (*N* = 112)

	n	%
Mental Health Treatment	**50**	**44.6%**
Law Enforcement/Probation and Parole	13	11.6%
Medical Emergency Services	11	9.8%
Primary Care/Physical Health Services	8	7.1%
Substance Use Treatment	5	4.5%
Crisis Intervention	5	4.5%
Case Management	4	3.6%
Education	3	2.7%
Housing Services	2	1.8%
Legal Services	1	0.9%
Other	10	8.9%

Note: Other primary services include guardianship, court services, and overall behavioral health services

Table 3. Primary ERE-Related Responsibilities (*N* = 120)

	n (%)
Identifying and making appropriate **referrals** to ERE	51 (42.5%)
Providing direct mental health services and/or treatment	23 (19.2%)
Managing received **referrals** from ERE	22 (18.3%)
Providing direct case management services	20 (16.7%)
Supervising project staff (related to ERE work)	16 (13.3%)
Providing other social services (e.g. substance use, housing, etc.)	16 (13.3%)
Providing direct medical services and/or treatment	11 (9.2%)
Providing transport	10 (8.3%)
Providing support regarding ERE data	8 (7.5%)
Providing peer support for ERE participants	5 (4.2%)
Other	15 (12.5%)

Note: Other primary ERE related responsibilities include administrative, Crisis response services, pharmacy, court support programming

Table 4. Specific Services Offered by Type of Provider Setting (*N* = 120)

	Total	CMHC	Hospital	Law Enforcement / P&P	SSA / Div. of DD	SUD Program	Primary Care
	***n* = 120**	*n* = 35	*n* = 30	*n* = 15	*n* = 7	*n* = 5	*n* = 4
	***n*(%)**	*n*(%)	*n*(%)	*n*(%)	*n*(%)	*n*(%)	*n*(%)
Mental Health Services	**71** **59.2%**	32 91.4%	22 73.3%	4 26.7%	1 14.3%	3 60.0%	2 50.0%
Crisis Services	**64** **53.3%**	28 80.0%	17 56.7%	7 46.7%	2 28.6%	2 40.0%	2 50.0%
Psychiatry	**60** **50.0%**	31 88.6%	20 66.7%	4 26.7%	1 14.3%	2 40.0%	2 50.0%
Community Based Assistance	**58** **48.3%**	27 77.1%	10 33.3%	6 40.0%	4 57.1%	3 60.0%	2 50.0%
Substance Use Services	**54** **45.0%**	28 80.0%	13 43.3%	4 26.7%	1 14.3%	4 80.0%	2 50.0%
Medication Assistance	**51** **42.5%**	26 74.3%	14 46.7%	3 20.0%	1 14.3%	3 60.0%	3 75.0%
Physical Health Services	**49** **40.8%**	17 48.6%	20 66.7%	3 20.0%	1 14.3%	1 20.0%	4 100.0%
Housing	**35** **29.2%**	20 57.1%	5 16.7%	3 20.0%	4 57.1%	0 0.0%	1 25.0%
Transportation Assistance	**35** **29.2%**	14 40.0%	9 30.0%	6 40.0%	2 28.6%	3 60.0%	0 0.0%
Basic Needs Assistance	**32** **26.7%**	12 34.3%	6 20.0%	4 26.7%	4 57.1%	1 20.0%	1 25.0%
Employment Services	**28** **23.3%**	18 51.4%	4 13.3%	3 20.0%	2 28.6%	1 20.0%	0 0.0%
Dental Care	**18** **15.0%**	10 28.6%	4 13.3%	2 13.3%	0 0.0%	0 0.0%	2 50.0%
Payer Assistance	**13** **10.8%**	3 8.6%	4 13.3%	0 0.0%	1 14.3%	2 40.0%	2 50.0%
Food Assistance	**12** **10.0%**	6 17.1%	0 0.0%	1 6.7%	3 42.9%	0 0.0%	1 25.0%
Legal Assistance	**10** **8.3%**	1 2.9%	2 6.7%	1 6.7%	1 14.3%	0 0.0%	1 25.0%
DD Services	**9** **7.5%**	3 8.6%	1 3.3%	1 6.7%	3 42.9%	0 0.0%	0 0.0%

Note: CMHC = Community Mental Health Center; P&P = Probation and Parole; SSA = Social Services Agency; DD = Developmental Disabilities ; SUD = Substance Use Disorder

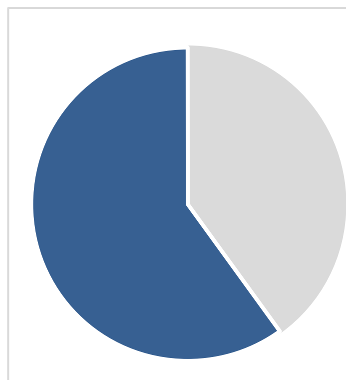
≥ 80% **≥ 60%** **≥ 50%**

III. Project Communication, Familiarity, and Clarity

Personal communication by survey respondents with their regional ERE administrative agent is detailed in Table 5. Only (58.3%) reported attending meetings with representatives from the ERE administrative site. Of those who did attend meetings, sixty percent of respondents indicated that these meetings occur at least monthly and "include representatives from other local agencies and organizations, in addition to representatives from the ERE administrative site." Respondents were also asked to indicate how familiar they were with ERE goals, implementation processes, and program outcomes (Table 6). We also examined the correlations among communication frequency and familiarity with goals, processes and outcomes (Table 7).

Figure 1 & Table 5. Frequency of Communication with Regional ERE Administrative Agent (*N* = 70)

	***n* (%)**
Once per year	4 (5.7%)
Twice per year	8 (11.4%)
Quarterly	10 (14.3%)
Every other month	6 (8.6%)
Once a month	37 (52.9%)
2-3 times per month	1 (1.4%)
Weekly	4 (5.7%)



60%

Respondents reported attending meeting with ERE site administrators at least once per month*

Table 6. Provider Familiarity with ERE Goals, Processes, and Outcomes (*N* = 110)

	Overall Mean	**(1) Not familiar**	**(2)**	**(3) Somewhat Familiar**	**(4)**	**(5) Completely familiar**
	(1-5)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
How familiar are you with the goals of the ERE program?	4.01	1 (0.9%)	2 (1.8%)	31 (27.9%)	38 (34.2%)	**39 (35.1%)**
How familiar are you with the processes involved in the ERE program?	3.82	1 (0.9%)	9 (8.1%)	30 (27.0%)	**40 (36.0%)**	31 (27.9%)
How familiar are you with the outcomes achieved through implementation of the ERE processes?	3.47	8 (7.3%)	19 (17.3%)	24 (21.8%)	**31 (28.2%)**	28 (25.5%)

A majority of respondents feel familiar with ERE goals, ERE processes, and outcomes achieved through implementation of the ERE project.

Table 7: Association between Meeting Frequency and ERE Familiarity Variables

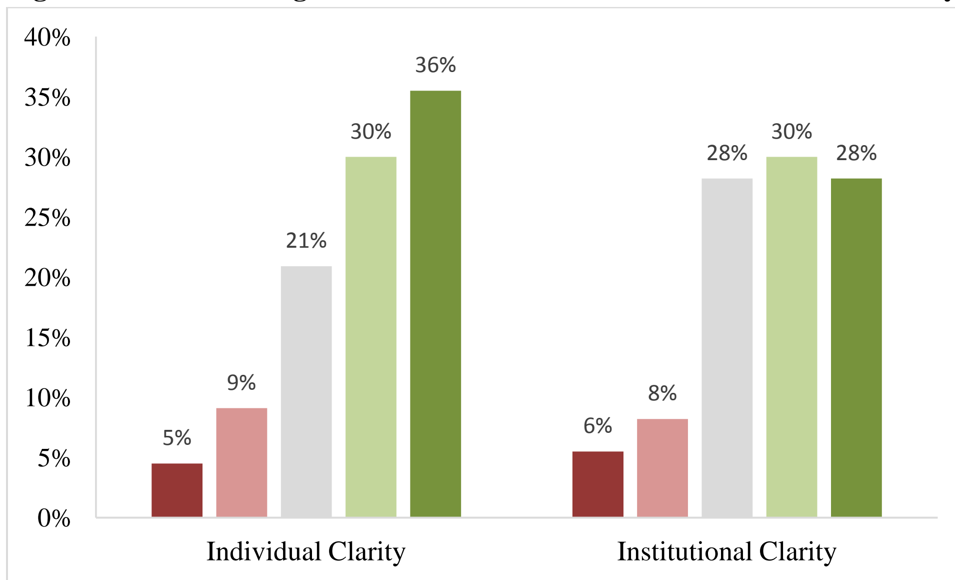
	Familiarity with ERE goals	Familiarity with ERE processes	Familiarity with ERE outcomes
Meeting frequency	-0.14	-0.17	0.24*
Familiarity with ERE goals	-	.81*	.73*
Familiarity with ERE processes	-	-	.82*

Note. *p <.05

As shown in Table 7, meetings that are more frequent are associated with greater perceived familiarity with ERE program outcomes, but not significantly associated with familiarity with ERE processes or goals. Perceived familiarity with ERE goals, processes, and outcomes, are all highly significantly associated with one another.

Role Clarity: Respondents were asked to rate their degree of clarity regarding their a) individual role as it relates to ERE and b) collective institutional role in the larger ERE program (Table 8). The majority of respondents endorsed a high level of individual and institutional Role Clarity. Correlations among familiarity and clarity ratings are shown in Table 9.

Figure 2 & Table 8: High Levels of Individual and Institutional Role Clarity (*N* = 110)



	Overall Mean	(1) No Clarity	(2)	(3) Some Clarity	(4)	(5) Complete Clarity
	(1-5)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
Individual Clarity	3.83	5	10	23	33	**39**
		(4.5%)	(9.1%)	(20.9%)	(30.0%)	**(35.5%)**
Institutional Clarity	3.67	6	9	31	**33**	31
		(5.5%)	(8.2%)	(28.2%)	**(30.0%)**	(28.2%)

Table 9: Association between ERE familiarity and individual and institutional role clarity

	Individual role clarity	Institutional role clarity
Familiarity with ERE goals	.67*	.69*
Familiarity with ERE processes	.68*	.68*
Familiarity with ERE outcomes	.58*	.61*
Individual role clarity	-	.84*

Note. *$p < .05$

Perceived familiarity with ERE program goals, processes, and outcomes were each significantly associated with respondents' clarity regarding both their individual role in ERE as a member of their agency and their agency's collective institutional role in the larger ERE program.

IV. Interagency Collaboration and Working Relationships

Shared Visions and Values (*N* = 107): To ensure buy-in and successful implementation of the ERE project, a strong foundation grounded in a positive working relationship must be established between not only the providers and consumers, but within all levels of the project. This includes the working relationships among the providers themselves as well as relationships between their organizations and their regional ERE administrative agent. When asked to rate the strength of working relationships, **77.8% of respondents reported strong or complete alignment between their personal and their organizations' vision and values.** Respondents were also asked to indicate which of four descriptive terms—cooperation, coordination, collaboration, or integration, with definitions provided for each of these terms—best capture the working relationship between their agency and the regional ERE administrative site. Slightly less than half (45.8%) selected collaboration or integration as most descriptive of this relationship. This is slightly lower than the 54.6% reporting these levels of cohesion in fiscal year 2017. It is difficult to determine the degree to which this reflects an overall change in level of cohesion versus differences in perspective between individual respondents across the two years. Nonetheless, with the goal of successful collaboration and integration of ERE services in mind, we will continue to assess the progression through the stages of effective interagency collaboration as outlined in Table 10 below.

Table 10: Defining the relationship between Agency/organization and ERE administrative site (*N* = 107)

	***n* (%)**
Cooperation: an informal exchange between agencies, with more or less frequent communication and a form of friendly coexistence.	30 (28.0%)
Coordination: involves some formal relations between agencies, whose staff will meet regularly to share plans, ideas, and joint activities, but each agency maintains its own set of goals, structures, and responsibilities, such that agencies are not truly accountable to each other.	28 (26.2%)
Collaboration: involves joint activities, joint structures, and shared resources. Partners have mutual benefits, interdependence, and a formal commitment of working together for specific purposes and outcomes.	**34 (31.8%)**
Integration: involves full integration in structure, attitude, and process. Roles overlap and are shared to a degree that goes beyond successful collaboration.	15 (14.0%)

Trust and Reciprocity (*n* =107): The 17-item Collaboration Scale developed by Thomson, Perry, and Miller (2007) was utilized in previous years to assess the level of collaboration among partners within the seven regions implementing ERE. This instrument is based on multidimensional model of five dimensions of collaboration: Governance, Administration, Autonomy, Mutuality and Norms (Thomson & Perry, 2006). Across all years of the project, Governance, Administration, Autonomy, Mutuality have been strongly endorsed, while perceived trust and reciprocity (measured by the Norms dimension) appeared to represent an area for improvement and was therefore the focus of this year's survey. On each of three questionnaire items, respondents were asked to rate how much they agree or disagree using a scale from "Strongly Disagree" (1) to "Strongly Agree" (7).

- Of the 107 respondents to this section, the vast majority (85.0%) agreed that "*partners in the collaboration are trustworthy*", 11.2% were neutral, and only a small proportion (3.7%) disagreed.
- Similarly, over two-thirds (76.6%) of participants agreed that their *"organization can rely on partners to meet their obligations for the collaboration",* whereas 5.6% disagreed and 17.8% were neutral.
- Over eighty percent (82.1%) of participants agreed *"it is worthwhile to stay, rather than leave, the collaboration"* – with 16.0% of respondents choosing neutral and a minority 1.8% disagreed.
- When collapsing all three items, the overwhelming majority (83.0%) of respondents positively perceived trust and reciprocity within the ERE program.
- When comparing 2018 survey results with those from previous administrations of the survey in all previous years from non-matched individual respondents (see Figure 1), perceived trust and reciprocity has steadily improved annually from 34.2% in 2014 to 83.0% in 2018.

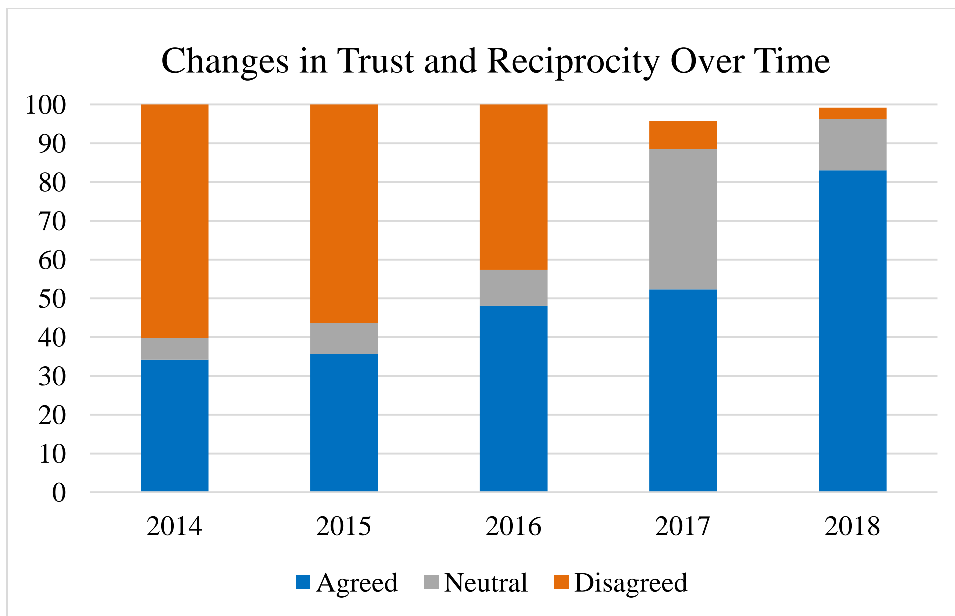


Figure 3. Changes in Trust and Reciprocity Overtime

83%

Of respondents believe the ERE program is valuable and project partners are reliable

Strengths in ERE Working Relationship, Qualitative Responses: Collaborators were asked to list three things that are going well with their ERE working relationships. Qualitative analysis indicated that the three most common themes listed were: **1) communication, 2) care coordination and 3) program and/or administrative coordination.** Collaborators who mentioned communication as a strength specifically appreciated ERE staff availability and responsiveness, transparency and holding of regular meetings. Collaborators explained how shared care plans and continuity of care between providers has helped improve care coordination for vulnerable populations. Program coordination was a common theme in responses, as collaborators commented on having an easy and timely referral process, familiarity with the ERE team at the administrative agencies and clear expectations attributing to strong working relationships. Examples of verbatim collaborator responses for each the three common themes are presented below.

Communication: The majority of responses (*n*=34) attributed their positive ERE working relationships to good communication.

- "Everyone has a voice and even if a suggestion isn't used, everyone's comments are heard and respected"
- "Communicate well to cover shortages and crisis"
- "…the city wide meetings are going well"
- "The staff is always available"
- "Open communication with transparency"

Care Coordination: Many responses (*n*=31) reflect on how care coordination has improved for the participants in the ERE program and how ERE working relationships are going well because of this improved care for participants.

- "ERE works very hard to ensure a safe discharge plan and has taken very complex cases"
- "Willingness to listen and collaborate on shared plans of care"
- "Can get to the matter quicker since the connections are made"
- "This provides increased/quicker access to care for the ERE clients"
- "Work hard to think outside the box to meet client needs"

Program/Administrative Coordination: Collaborators emphasized in comments (*n*=31) that the administrative coordination of the ERE program in their area is what is going well with their working relationships.

- "Easy referral process"; "Coordination is relatively easy"; "Process is consistent"; "Expectations are clear"
- "I know who to contact if I have an individual who needs to be referred to the ERE program"
- "Program coordinator is responsive when needed"
- "Administrative support is timely"

Aspects of ERE Working Relationships *in Need of Improvement,* Qualitative responses: Collaborators were asked to list three things that could be improved regarding their ERE working relationships. The three themes that were identified were: **1) collaboration, 2) program coordination and 3) knowledge of the ERE program.** A need for improved collaboration between agencies and with the administrative agent were endorsed as well as specific ways coordination could be improved. Respondents also commented on how they would like more information about the ERE program pertaining to program goals and outcomes. Respondents also listed additional service resources needed including housing resources (*n*=4), substance use resources (*n*=3), an overall awareness of resources available (*n*=2) and transportation resources (*n*=1). Examples of participant responses are provided below for each of the top three common themes around areas in need of improvement.

Collaboration: Most responses (*n*=12) suggest that improving the collaboration efforts between existing ERE partners and increasing collaborations with new partners could improve the established ERE working relationships.

- "More integration/collaboration with hospitals"; "Better working relationship with physicians in the ER"
- "Perhaps more coordination between prescribing doctor and P&P"
- "Collaboration with outside community services other than law enforcement"
- "Referrals from the police department, to prevent from unnecessary jail time"
- "More control/involvement with the court system-Mental health professionals should be considered a strength and a partner"

Program Coordination: Many comments (*n*=11) offer suggestions on how some ERE program coordination efforts could be focused in order to improve ERE working relationships.

- "Improved communication/responsiveness with new ERE [team members]"

- “Better communication and referral process from EDs”; “Notice when referrals have dropped off”
- “Education on systems and processes”

Knowledge of the ERE Program: Some comments (*n*=11) focus on how sharing knowledge about the ERE program, its goals, processes and outcomes are important to improving ERE working relationships.

- “Greater understanding of what the program's current goals are”
- “More contact and information from [agency] about the ERE program”
- “Need more knowledge about the vision of the program”
- “Outcome measures of the work”; “Knowledge of outcomes”

Improving ERE Working Relationships**, Collaborators’ Suggestions:** Collaborators were asked what specific suggestions they had for improving ERE working relationships. Below are verbatim comments from respondents offering suggestions on how to improve ERE working relationships.

Collaboration:

- “It would benefit the community to have 24/7 ERE case management services assigned to each ED for the after-hours and weekend needs. Work harder on getting referrals from the ED. Currently most referrals are being made from inpatient units. Response times to the EDs and referrals from the EDs is lacking”
- “I think the ED needs to have more 'fluid walls' when it comes to embracing post-acute care providers for those who are in the ERE program. Once a patient leaves the ED and more importantly, once a patient is considered 'stable' and more self-managed, it is imperative that the patient's community healthcare agencies stay connected and involved with the ERE program and to do this, they need to understand it more. I'd like to see a post-acute care outreach of education to primary care physicians and health care clinics.”

Program Coordination:

- “Increasing the number of meetings between supervisors of the programs from various agencies. Giving the ERE coordinator more oversight power over ERE outreach workers”
- “The limited number of "spots" available for patients makes it difficult for consistency at a very busy referral site. The more limitations for referrals the harder it is for a consistent process to be developed. An automated quarterly report to referral sites listing current activity and past trends would be helpful.”
- “I would like to have more frequent (monthly) case conferences about enrolled clients and have larger, less client specific meetings quarterly.”
- “More timely referral time for case managers to be on board more involvement with case managers to clients more communications from admin and case managers to guardians”

Knowledge of the ERE Program:

- “Our agency is not clear on the goals of the ERE”
- “In-services and/or trainings within the community to educate agencies and individuals regarding the ERE program.”
- “Training with law enforcement to make them aware of available services.”
- “Re-educate our facility; communicate with our facility”

V. Program Implementation: Strengths, Weakness, Improving in the Future

To assess the collaborators' perception of the project implementation, survey participants were asked to provide information pertaining to successes, challenges, and opportunities for improvement. Overall, participant's felt ERE implementation was successful in meeting overall project objectives (Table 11)

Table 11: Perceived Level of Success Meeting ERE Program Objectives

	Mean (1-5)	(1) Very Unsuccessful		(2)		(3) Neutral		(4)		(5) Very Successful	
		n	(%)	*n*	(%)	*n*	(%)	*n*	(%)	*n*	(%)
1. Coordinating multidisciplinary care for high-need populations	3.9	1	1.0%	3	3.0%	23	23.0%	**51**	**51.0%**	22	22.0%
2. Improving inter-agency coordination and collaboration	3.9	1	1.0%	4	4.0%	23	23.2%	**47**	**47.5%**	24	24.2%
3. Improving clients' quality of life	4.0	0	0.0%	1	1.0%	23	23.2%	**53**	**53.5%**	22	22.2%
4. Connecting and engaging clients with mental health services	4.1	0	0.0%	2	2.0%	17	17.2%	**52**	**52.5%**	28	28.3%
5. Connecting clients with housing services	3.6	1	1.0%	9	9.1%	35	35.4%	**41**	**41.4%**	13	13.1%
6. Connecting clients with substance use treatment services	3.8	0	0.0%	4	4.0%	30	30.3%	**45**	**45.5%**	20	20.2%
7. Engaging in follow-up care with clients	3.9	0	0.0%	2	2.0%	28	28.6%	**47**	**48.0%**	21	21.4%

Barriers and Limitations for ERE Implementation

Over half of respondents identified lack of capacity/slots/beds (56.5%) and lack of financial resources (48.4%) as significant barriers to implementing ERE. In an improvement from FY17's report, only a minority of respondents reported documentation load and staff/personnel capacity as a barriers to implementing ERE services. Furthermore, most respondents felt knowledge about ERE services and communication among collaborating agencies were not a barrier to implementing ERE.

Table 12: Barriers to ERE Implementation (N = 94)

	Mean (1-5)	(1) Never a barrier		(2)		(3) Sometimes a barrier		(4)		(5) Always a barrier	
		n	(%)	*n*	(%)	*n*	(%)	*n*	(%)	*n*	(%)
Documentation load	2.5	19	21.4%	24	27.0%	**34**	**38.2%**	8	9.0%	4	4.5%
Lack of capacity/slots/beds	3.5	12	13.0%	8	8.7%	20	21.7%	**31**	**33.7%**	21	22.8%
Lack of financial resources	3.5	9	9.9%	8	8.8%	**30**	**33.0%**	20	22.0%	24	26.4%
Lack of staff/personnel	2.8	13	14.1%	21	22.8%	**38**	**41.3%**	16	17.4%	4	4.4%
Lack of knowledge about services available through ERE	2.5	25	26.6%	20	21.3%	**29**	**30.9%**	14	14.9%	6	6.4%
Lack of communication among collaborating agencies	2.6	15	16.0%	27	28.7%	**34**	**36.2%**	13	13.8%	5	5.3%

ERE Implementation ***Gaps in Services,*** **Qualitative responses:** Respondents were asked to think about the services they provide for ERE participants, as well as those they do not provide, and list up to three gaps in services they perceive to exist for the ERE participant population. **Below are the top three themes that emerged from the qualitative analysis with representative quotes regarding what respondents feel are gaps in services: lack of housing (n=29), lack of transportation (n=14), and programmatic improvements (n=13).**

Housing (n=29) Lack of housing was the most identified gap in services indicated by the responses of the collaborators of the ERE program. Collaborators specified in their responses that a variety of housing options were needed such as emergency/crisis, temporary, long term, recovery-based, gender specific (especially female), and single occupancy housing. Responses also included access to affordable housing or funds to help with rent or utilities or structured housing for individuals with mental needs. Sustainable housing was indicated as a need in several responses with one respondent stating, "Often temporary housing is provided but there is a lack of resources to keep people housed long term."

Transportation (n=14) Lack of transportation was also identified as a gap in services by the ERE collaborators. Transportation assistance is necessary for clients to be successful in the program as improves access to appointments (psychiatric, physical health, therapy/counseling etc.) and to basic needs they may otherwise not be able to access (medication, food, education, etc.).

ERE Program Improvements (n=13) Many responses indicated that there could be improvements made to the ERE program overall. Collaborator responses mentioned several gaps including an absence of awareness or understanding of the ERE program, lack of consistency in the process and support, staffing issues, and a need for increased communication. Collaborators felt that awareness of the ERE program could be improved in several areas including emergency departments, law enforcement, with the larger community, and with other service providers. One collaborator responded, "Emergency department staff may not be aware of program if they are not in the behavioral health service line" and another "Law enforcement needs to understand how they may benefit from working together [with the ERE program]."

Furthermore, medication assistance (n=8), psychiatric care (n=6), crisis intervention services and resources (n=6), and access to insurance or Medicaid (n=6) were also commonly listed as gaps by respondents.

How ERE Program Can Improve in Meeting Program Objectives, **Qualitative Responses:** Collaborators were asked to elaborate on how the ERE program could improve in meeting the ERE objectives. Most responses (*n*=13) focused on the need for additional housing resources. The need for substance use resources were also endorsed (*n*=7). Below are comments from respondents regarding how the ERE program could improve in meeting the objectives listed above.

- "Plain and simple: funding and access to resources. Some of our clients have such high needs in multiple areas that it is difficult to find resources to manage them all at once. This leads to clients going back and forth with their success. Connecting clients with MH services can be extremely difficult when they are chronically homeless and we operate on a catchment area. Housing is a nightmare. Even clients with income have extremely long (1-2 year) waiting lists for housing. If we house them temporarily, then they don't qualify for chronic homelessness programs. It's difficult to engage in follow up care if you spend long hours just attempting to locate the clients. Substance use treatment is a hit/miss in regards to funding and bed availability."
- "The ERE Program does an amazing job. They do as much as they can with the funding that they have. It was my understanding that they were going to be able to assist individuals with temporary Medicaid and assist with finding a job. There is such a high homeless population here and substance use issue it is hard to be consistent in efforts when there are no funds to push it. Most of these individuals are self-pay and have no resources."
- "Sending out reminders and feedback about the programs utilization, impact and success will motivate frontline staff to be more engaged."

Impact of ERE on Providers and Clients: Limitations, Highlights, and Success Stories

Respondents rated their perceptions of the ERE program level of success in meeting their clients' needs. In addition, respondents offered more specific comments on the overall benefits and positive effect of ERE as well as areas in need of improvement to best serve clients.

Table 13: Perceived Level of Success in Meeting Participant Needs (*n* = 98)

	Mean (1-5)	(1) I never feel successful in meeting their needs *n* (%)	(2) *n* (%)	(3) About half the time I feel successful in meeting their needs *n* (%)	(4) *n* (%)	(5) I always feel successful in meeting their needs *n* (%)
Think about your role in meeting the needs of the ERE participants (patients, clients, customers, etc.) with whom you work.	3.8	0 (0.0%)	6 (6.1%)	23 (23.5%)	**59 (60.2%)**	10 (10.2%)

Overall beneficial impact of ERE: On a five-point rating scale, the majority of respondents endorsed feeling successful in meeting their clients' needs at least most of the time (70.4%) while about a quarter (23.5%) felt they were successfully meeting their clients' needs about half of the time (Table 11). On an open-ended item, respondents were asked how they would describe the overall benefits of the ERE program. The three themes that emerged from qualitative analysis included: 1**) consumer access to services, 2) improved care coordination, and 3) improved consumer quality of life.** Representative responses are listed below reflecting each of these overall benefits of the ERE program.

Consumer Access to Services (n=26)

- "Providing immediate case management to meet the needs of individuals prior to them having to go through formalized intake processes at agencies in which they often fail or fall through the cracks."
- "Most of our clients do not have any support system and are so overwhelmed that they do not even know where to begin. The ERE workers are able to take them by the hand and help guide them to the services that they need. I have seen them do amazing work and really try to help get them stable on the limited resources they have."
- "The ERE program is one of the few programs [in the area] that are able to help underfunded or people without any form of funding find and access needed mental health services. It has decreased some of the "frequent fliers" to our hospital who were readmitting due to no follow up care or being able to access psychiatric care."

Improved Care Coordination (n=13)

- "There is much better understanding of high utilizers across systems, and better coordination between EDs and outpatient providers."

- “It is ideal to have a place that a person can go, who is in crisis, and have a thorough assessment and plan for future care. Rather than going to the ER for a band aid.”
- “The staff with the ERE program provide benefits that far outweigh ‘just individuals that repeatedly use the ER’ They have assisted in many aspects as a service to individuals while on waiting lists at other facilities for mental health care or getting scripts filled so individuals don't have mental health emergencies.”

Improved Consumer Quality of Life (n=10)

- “I would describe the overall benefits of the ERE program in our area, as a collective set of resources available that provides assistance for the initial level of stability, that may serve as the foundation for success in long-term management or recovery for individuals.”
- “It is a wonderful program and has helped several of our patients to achieve higher goals for themselves.”
- “Overall, just having a Case manager from the ERE programs tend to have an overall positive effect on client's and their belief that they can live a more stable life. The improvement in their hope alone sparks slow improvements in their stage of change and an overall improvement in their quality of life.”

Improving ERE Consumer Outcomes, **Qualitative Responses:** Respondents were also asked to provide suggestions for improving outcomes for ERE participants. The survey stated that suggestions could focus on major outcomes related to mental health, employment, housing, involvement in the legal system, or other areas related to overall quality of life. The two major themes that emerged from the responses to this question were **1) interagency coordination and communication and 2) increased consumer housing resources.**

Interagency Coordination and Communication (n=9)

- “Having an accessible community, regional medical and behavioral health plan for these patients would be valuable. A psychiatrist and internist who work together and are responsible for the care plan of the patient along with providing contact numbers when questions arise could improve coordination of services for this patient population. The care plan would be available to healthcare facilities in our region to access when the patient arrives at a care facility. The care plan should touch on the medical, behavioral health, housing, social, and legal needs of the patient.”
- “More coordination! We have multiple agencies in the area that as a whole can provide support for a variety of needs but we are rarely in a room together offering to assist.”
- “Continue to enhance collaboration across community agencies and groups. Involve EMS/CIT officers more. Conduct brief educational in-services on program & services for hospital social workers and case managers.”

Increased Consumer Housing Resources (n=7)

- “Increase funds to assist with housing or supported halfway homes
- “Creating housing that is specifically for participants would benefit the lack of beds. If clients are forced to return to a shelter, they lose faith in the case worker/agency and their ability to actually make a change in their life.”

Other frequently mention suggestions included increased bed capacity (n=4) and increased funding (n=4).

***Opportunity for Growth*, Qualitative Responses:** Collaborators were also asked for examples of ERE participants that they believed could have benefitted more from the ERE program if certain aspects of the program or services had been different. Respondents shared incidences where clients needed more than the program provided.

Basic Life Skills

- “There have been multiple situations with regard to consumer's served who were set-up for success (medication management, emotional regulation, housing, employment), but do not have the "basic life skills" foundation

(money management; financial responsibilities) to maintain stable housing, bills, food, etc. As a result, they cycle back into similar situations and outcomes that resulted in ERE services. Establishing a program before discharge for appropriate consumers, that would provide education classes for maintained stability (basic life skills), may be a method of interest to include in effort fulfill this particular opportunity for growth."

Housing Resources

- "We had a [client] who was cycling in and out of substance use treatment programs and recovery housing, with little success. He was unable to maintain any significant period of clean time and overdosed (and subsequently died) in the past month. It seemed that we were unable with our current resources to have any lasting impact on his use. It was particularly difficult for him to transition successfully from inpatient to outpatient care, and recovery based housing required him to work to sustain himself in that housing. He did not have SSI, so had limited funds for housing. He needed a longer term structured/supportive setting before he was expected/required to work."
- "I have a client that has significant physical health with substance use that frequents emergency rooms several times a week. I have not been able to house him with in home health aid due to income and housing options. This client could benefit from just having a stable home environment to return to. However, due to limited funding for housing assistance, the client's income alone is not enough to get him into housing without a 1-2 year waiting list. Therefore, client has made no progress in the last 2 months since being referred for services."

Eligibility Requirements

- "We see patients regularly who could benefit from the ERE program but currently don't meet criteria for the program. Eventually these patients probably will meet criteria. The ERE program focused on high utilizers is currently more reactive then preventative. Hopefully resources through the ERE will increase in the future so it can prevent patients from becoming high utilizers."

Access to Staff/Services

- "Several clients could have benefited from an immediate substance abuse treatment program but there is always a waiting list."
- "I believe that many of my folks whom I am guardian for could benefit much more if they had case workers who had more time for them, who were trained better, who were able to do more for them, and if the case workers and administrators of the mental health agencies had more communication with guardians."

Impact of ERE on provider's view of high utilizers

As shown in Table 14 below, over 60% of survey respondents indicated that their views of emergency department (ED) high utilizers had become somewhat or much more positive as a result of their work on the ERE project, and no respondents reported a more negative view of these clients based on their work experience.

Table 14: Impact of ERE program on provider views of high utilizers of the emergency department (ED)

	Mean (1-5)	**(1) More negative *n* (%)**	**(2) *n* (%)**	**(3) Un-changed *n* (%)**	**(4) *n* (%)**	**(5) More positive *n* (%)**
How has how ERE changed your perception of emergency department high utilizers	3.6	0 0.00%	4 3.96%	**43** **42.57%**	**42** **41.58%**	12 11.88%

Association between perceived ability to meet needs and views on high-utilizers: There is a positive correlation between respondents perception of meeting ERE participant needs (Table 11) and their rating of changes in how they perceive high utilizers of the ED (also 1 to 5 scale, 1="My views are much more negative" to 5="My views are

much more positive") $r=.43$, $p<.001$. <u>This finding indicates that the higher perceived ability to meet ERE participant needs is associated with greater positive change in respondents' views of high utilizers</u>.

Provider Success Stories – Collaborators Elaborate on *Views of High Utilizers*, Qualitative responses: Collaborators were asked to elaborate on how their views of high utilizers of the emergency department have changed based on their involvement in the ERE program. Below are verbatim comments from some respondents on their views.

- "ERE Involvement has helped me SEE clients in need as people who need a hand up, not just a hand out. The people at [agency] really help me to understand that we are all just a step away from being in one of our client's situations and the level of commitment to persevere has inspired me personally as well as professionally. I marvel at their degree of willingness to help someone and yet their professionalism in setting healthy boundaries as well. Once I asked one of the ERE administrative team members how they did it and they said, 'I have seen so many people actually change, that it gives me the hope that this next client 'could be that one' and I keep going!' Amazing!"
- "My experience working with ERE has given me the opportunity to observe the various complexities (cognitive, emotional, and behavioral) that lead many high utilizers in their decision making, which in turn provides me with a broader understanding for direction in providing appropriate services. Further, I am able to better recognize my bias and over generalizations in response to various populations, providing me with a greater level of compassion and insight."
- "These folks need help and usually have no means to pay for it. Their problems are ongoing and require meds, counseling and usually assistance with housing and everyday life. These problems will not be "solved" for most of them, only managed. ERE is a huge help to P&P in getting assistance while waiting to get in MH-3 Program. ERE ladies also are great about helping clients apply for disability and social security. They know their way around paperwork!"

Client Success Stories The inclusion of client success stories was identified in the 2018 Collaborator survey as a way to convey the importance and impact of the ERE project for the people that we serve. Respondents shared numerous stories of client success and below are five examples covering different types of success.

Reduction of ER Utilization

- "A client was able to obtain access to a long term substance use program which resulted in stable housing and sobriety for 9 months. This drastically reduced his use of ER/hospital services and ended a period of homelessness for him."
- "We outreached a [client], diagnosed with Schizophrenia who had been in foster care and estranged from family. He was homeless, and had not been successful staying connected to service previously. He was referred to ERE for frequent ED use and hospitalizations, was readmitted to outpatient mental health services, connected to our Young Adult team, and is now housed in Permanent Supported Housing program. He has not been hospitalized since his enrollment in ERE."
- "A client who is a legal immigrant but with minimal English skills, a history of traumatic brain injury and substance abuse issues. Partnering with an agency that specializes in helping immigrants we have been able to get him housed and have begun applying for Medicaid and SSI. He has gone from multiple ED visits weekly to zero. He wants to be working, so we'll be addressing that next!"

Stabilizing mental health

- "Several months ago, an individual in their late twenties (whom was homeless at the time) was referred to ERE services from the local hospital's behavioral health unit. Consumer experienced severe bipolar symptoms with psychotic features, and was immediately enrolled into ERE services. While in ERE program we were able to provide consumer with appropriate psychiatric, psychotherapeutic, and care coordination services resulting in successful medication management, emotional regulation/monitoring, and obtained employment and permanent

housing. During last session with consumer, he expressed gratitude for ERE services, as well as new found hope and purpose, which he shares has been absent from life for as long as he could remember. Consumer has been successfully maintaining employment, housing, and his mental health for the past 2 months."

- "I just transferred a client after 18 months. When client was assigned, he had been wondering the streets in a complete psychotic state for 3 months, lost everything and was not engaging in services at all. He finally got into permanent independent housing and re-established with traditional case management and med management with a 12 week injection. The case manager he was referred to had actually worked with him 2-3 times as a fill-in prior to his engagement in ERE. The case manager stated, 'He's not even the same person. I would've never known he suffered from such severe mental illness had I not seen him 2 years ago before he was sent to ERE.'"

Stabilizing Substance Use

- "I have worked with a [person with alcohol use disorder] for the past 3 yrs. This year she has been clean and sober. She has reconnected with her family, been doing volunteer work and she presents at our CIT trainings. She has come such a long way. About every cop in our county has arrested her 5 or more times due to public intoxication. She is now hugging our police officers thanking them for all the times they tried to help her. She has really turned her life around and I feel that it would not have been possible if it was not for the ERE Program and joint efforts of all the providers working together."

Homelessness to stability

- "[The client] who struggles with staying clean, being back and forth between 2 agencies where she has a worker at both for 2-3 yrs., she was finally able to sit through a group, with taking her psyche medication regularly, and moving up to staying in group for a full day, to getting her housing voucher, so that she doesn't have to be homeless anymore, She is getting better."

Trauma-informed Care

- "One of my patients with high ED visits, substance abuse and heart issues was kicked out of her mother's home after discharge from the hospital. She'd been on the 'watch' list for the ERE administrative team, but had refused intervention previously. The day after discharge the patient called me and told me she was living at a bus stop and was having SI. I called the ERE team and they dispatched a police officer, but she apparently refused to talk to the police. I called the ERE team back and they agreed to send a female case manager to visit with the patient. Long story short, the patient agreed to the help of the ERE team who assisted her in getting her things from her mother's, agreeing to behavioral health treatment and even consenting to drug rehab. I know this patient is alive today because of their intervention, which I called 'above and beyond!' The team worked a bit beyond the boundaries of the emergency department on this one (after ongoing perseverance to establish a relationship with this patient in the ED) to save her life. To my knowledge, this patient is still periodically engaged with the case manager who extended a hand of life to this patient when she was in crisis. Of note is that later when I talked to the case manager from the ERE team, I was told that the patient had early onset trauma and was benefiting from trauma informed care. They know what they are doing and a difference is being made.

VI. Overall Summary

Overall, respondents to our ERE Collaborator Survey reported strong identification with the ERE program and its goals, positive views of project administration and interagency collaboration in their regions, and that ERE is effective for clients at the level of specific outcomes (this perception is also supported by outcome data) and overall quality of life. At the same time, respondents described challenges and areas for growth within regional collaborations and in the array of services available for clients.

Project Communication, Familiarity, and Clarity

- 60% of respondents reported attending meeting with ERE site administrators at least once per month
- Majority of respondents feel familiar with ERE goals, ERE processes, and outcomes achieved through implementation of the ERE project (Table 6)

- The majority of respondents endorsed a high level of individual and institutional role clarity which were both also associated with high levels of familiarity with ERE project goals, processes, and outcomes.

Interagency Collaboration and Working Relationships

- The survey found evidence for a positive collaboration and even some integration in services
- Data across survey years, while not based on matched respondents, suggest an increase in perceptions of trust and reciprocity across agencies in FY 2018 as compared to previous years. Perceived trust and reciprocity has steadily improved annually from 34.2% in 2014 to 83.0% in 2018 (Figure 1).
- A large proportion of respondents reported a strong alignment between their respective agency/organization and the ERE administrative agency.
- In open-ended questions, collaborators identified areas that are going well with their ERE working relationships including communication, care coordination, and program and/or administrative coordination.
- Collaborators also describe areas that could be improved regarding their ERE working relationships including collaboration, program coordination, and knowledge of the ERE program.
- Results indicate the differing strengths and weaknesses within each administrative region and offer feedback and suggestions for not only what to improve but how to improve areas that might need to be strengthened.

Program Implementation: Strengths, Weakness, Improving in the Future

- Many collaborators reported that their involvement in the ERE initiative has elevated confidence in service delivery and coordinated care for their clients as well as improved access to a larger network of resources
- The majority of respondents felt ERE was successful in meeting program objectives overall.
- A number of barriers to effective implementation of ERE services were apparent with over half of respondents reporting lack of capacity (i.e., treatment slots or beds) and lack of financial resources as a significant barrier.
- Respondents also endorsed a need for more interagency coordination and communication as well as more access to housing resources for consumers with specific attention paid to housing options that support medication assisted treatments for SUDs.
- Consistent with these concerns, gaps identified in ERE services included lack of housing, transportation, and overall implementation improvements in the ERE program itself.

Impact of ERE on Providers and Clients: Highlights, Limitations, and Success Stories

- Respondents indicated that the ERE project has had numerous benefits for the clients they serve as highlighted by both the provider and client success stories.
- Overall benefits of the ERE project identified by respondents include improved consumer access to services. Improved coordinated care, and increased quality of life for the clients.
- The survey also helped to identify areas of improvement including improvements in interagency coordination and communication and increased consumer housing resources.
- Opportunities for growth include providing support for basic life skills development, housing resources, revising eligibility requirements and increased access to staff and services.
- That said, ERE continues to make a significant positive impact on both providers and clients as indicated by the shared success stories.

Next Steps These findings, taken together with previous years' collaborator survey and interview responses, support the essential need for continual evaluation of the program that includes multiple perspectives. These evaluation efforts can ensure not only that patient outcomes are improving but also that service providers and their agencies are engaged and feel supported by the ERE program. Future surveys may include additional items to measure progress and barriers in collaboration and implementation. Qualitative items that were included in the Year 5 Survey amplified quantitative ratings by identifying specific areas of strength as well as areas of improvement as experienced by ERE service providers. Continued refining of both the ERE program and evaluation will be essential to building on strengths and address limitations and gaps. Moving forward, MIMH, DMH, and the Coalition will continue to collaborate to ensure the ERE program is consistently supporting and improving the coordination of care for individuals in need of services for

psychiatric symptoms and/or substance use disorders, improving clients' lives while increasing the efficiency and reducing the cost of their care. To achieve this goal:

1. MIMH and the Coalition will work to increase the rate of participation to ensure all providers are represented and findings are generalizable to the ERE project and beyond.
2. MIMH will work with the Coalition, elicit feedback from DMH, and discuss future survey implementation and review of survey questions to maximize the utility of this assessment and report.
3. MIMH, DMH, and the Coalition will work together to develop strategies to address the areas for improvement as detailed in the report by continuing to monitor perceived trust/reciprocity, program gaps identified (e.g., increasing perceived collaboration and integration, improving access to and efficiency of network/resources, and enhancing administration and implementation logistics).
4. DMH, the Coalition, and MIMH will strategize, based on collaborator input, about how to improve access to specific types of services that clients may not be getting at sufficient levels (e.g. housing and substance use treatment).
5. MIMH will elicit feedback from DMH and the Coalition regarding best practices for disseminating information included in this report to participating ERE providers and staff, if appropriate.

References

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