Grants to Expand Care Coordination Through the Use of Technology Assisted Care in Targeted Areas of Need (TCE-TAC)

RFA # TI-11-0023792

CSAT BIANNUAL PROGRAMMATIC REPORT

Program Reporting Period: 4/1/2014-9/30/2014

Instructions for Completing this Report

1. Save the report to your computer.
2. Click on the darkened box next to each item to fill in your response.
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TCE-Technology Assisted Care (TAC)
SAMHSA/CSAT
1 Choke Cherry Road, Room 5·1055
Rockville, MD 20850

1. Reporting Period: 4/1/2014-9/30/2014

2. RFA #: TI-11-0023792

3. Grantee: First Call Alcohol/Drug Prevention & Recovery

4. Provider Site(s):

Provider Site Name	Address	Contact Person	Phone/Email
First Call Alcohol/Drug Prevention & Recovery	9091 State Line, Kansas City, MO 64114	Molly O'Neill, President and CEO	816-361-5900

5. Project Director: Ken Ortbals

6. Evaluator: Dr. Thomas Gregoire

7. Evaluator Phone/Email: gregoire.5@osu.edu; 614-288-7657

8. Signature Ken Ortbals 10/30/2014

Project Director Signature Date

9. List any changes in key staff contact information here:

Staff Member	Add/Loss	Effective Date	Email	Phone
N/A	N/A	N/A	N/A	N/A

Staff Member	Add/Loss	Effective Date	Email	Phone

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BACKGROUND

Provide the abstract from your grant application. Specify all technologies being used in the project and any changes from the initial application.

Abstract:
First Call requests $278,045/year for three years for Mobile MET, a person-centered Motivational Enhancement Therapy (MET) project designed to increase clients' motivation for sustained engagement with treatment providers through the use of web-based tools/client portal. The population to be served is uninsured and underserved individuals aged 18 and over who reside in Jackson County, Missouri accessing services at 24 community behavioral health and mental health agencies funded by the Jackson County Community-backed Anti-drug Tax (COMBAT). This population is part of the Kansas City/West Central Missouri Access to Recovery Targeted Area of Need. The vast majority of the target population seeking residential treatment experience a wait period of three to four weeks; this project is designed to sustain engagement through the wait list period.

The Mobile MET goal is improved client access to treatment and increased client engagement with providers. Mobile MET will provide Motivational Enhancement Therapy (MET), an evidence-based intervention, by supporting increased, person-centered motivational interviewing and communication between the client and provider. Participating clients will engage with providers via a client portal built into the Community CareLink (CCL) shared Electronic Medical Record (EMR) that includes encrypted email; text messaging; and electronic enrollment forms, screening tools, appointment scheduling, and assessment tools, including the Addiction Severity Index Multimedia Version (ASI-MV). CCL is the current EMR utilized by the above 24 agencies. Mobile MET outcomes, in alignment with SAMHSA's National Registry of Evidence Based Programs outcomes for Motivational Enhancement Therapy, include: 1) decreased substance use, 2) decrease marijuana use, and 3) decrease in marijuana problems. In addition to these already established outcomes associated with MET, our project hopes to: 4) increase retention among pre-treatment clients who used Mobile MET services and 5) increase treatment retention for clients who utilized technology based services from treatment admission to discharge.

The technology being utilized is Community CareLink, First Call's proprietary electronic behavioral health record. We custom built the web portal as part of the Community CareLink software. We built text messaging capability within the database, rather than using a third party product. We are still on track with our initial proposal. We built the interface with the ASI-MV, which was a major objective for Year 2/Year 3 timelines, but we determined we lacked the demand/need to integrate it into the Mobile CCL portal, so we did not proceed with the use of that software component.

The portal includes the following features: client ability to add/edit contact and demographic information, secure messaging center, assessment summary, client ability to add/comment on treatment plan tasks, client assignments and worksheets. All data is stored in secure CCL database and text/email notifications are sent to inform clients of portal activity. Clients and clinicians receive notifications of activity (in the client's portal and their file, respectively).

**Our project is named Mobile MET (Motivational Enhancement Therapy) but for branding reasons, we decided to co-brand it with our EBHR, Community CareLink which usually is referred to as "CCL". We recognize that the project itself is called Mobile MET, but we have opted to refer to the actual mobile tools as Mobile CCL. You will see the this report reference both names, but we use the term "Mobile

CCL" for most occasions.**

PROJECT IMPLEMENTATION

Project Goals and Objectives

Provide status reports of all current project goals and objectives, including lessons learned and best practices using the technologies.

Goal: Market the Client Portal

Status: We started exploring marketing strategies in Year 2 of the grant. We utilized Google Analytics and custom URL tags for any web links so we could track traffic into the MobileCCL.org website as a result of the marketing campaigns. This tracking enabled us to make informed marketing decisions/expenditures. The project manager invested time in the Google Analytics Academy to ensure that we're making the best use of this resource.

As a result of our use of Google Analytics, along with the responses from various marketing strategies in Year Two, we opted to stick with bus ads, web-based click through ads, and radio spots for our primary marketing strategies over the 2nd and 3rd quarters of Year 3. We saw the highest increase in web traffic while the web ads were running (258 new visits attributable to this marketing strategy.) Word of mouth and anecdotal feedback indicates that radio ads were very helpful to raise the profile of First Call as an agency, as well as inform the community about the Mobile CCL resource. Overall, over the past 6 months, the MobileCCL.org site got 746 web hits.

Goal: IT Support

Status: Luckily this reporting period required far less IT support. The best use of our time was streamlining the client enrollment process into the intake process for clinicians. We still have some users asking about forgotten passwords but that is another easy fix, as w espent the time giving users the ability to reset their own passwords earlier in the grant.

Quite a bit of IT support time has been dedicated to supporting the project in mid-Missouri -- our fellow SAMHSA grantee Randolph County Caring Community. They are replicating many elements of our workflow and project, including the use of our EBHR Community CareLink and the client portal, which they named Mobile CASE. We see this project as a vital testament to the sustainability of the Mobile CCL project.

Goal: Product Enhancement

Status: As noted in the last report, our focus for product enhancement centered on text messaging and really implementing a meaningful way for clients to receive text notifications, messages, etc. We had already implemented a system for clinicians to receive texts rather than email notifications regarding client use.

During this reporting period, we added the ability for clients to receive text notifications. We built this straight into the Community CareLink software, meaning, by asking for a client's cell phone number and carrier, we are able to route notifications to them via text message (as well as by email). Building this ability into the software is a very natural, sustainable solution to what could be a costly strategy to implement. In the coming months, we are going to start using this technology to send appointment reminders as well. Adding the ability to text clients was really the extent of product enhancement over this reporting period.

Goal: Sustainability Planning

Status: Mobile CCL has become a core component of our Community CareLink software. As we worth with other communities in agencies to implement the software, the portal is yet another feature that draws interest. For example, we are working with another SAMHSA grantee, Randolph County Caring Community to implement Community CareLink and their own rendition of the Mobile CCL portal. We are able to train and support the use of the portal seamlessly as part of our general CCL product support. This partnership has shown that it's truly a sustainable technology in terms of scalability, low economic burden, and ease of adoption. We are excited to continue to leverage the client portal as part of our CCL software; thus, sustaining the initial investment that SAMHSA made.

The prior paragraph was written for the past report but it is so important that it's worth restating. We put a huge priority and focus on sustainability. For example, we built text messaging capability into the software rather than adding a third party software into the project. We continue to put a big focus on helping Randolph County work through their IT and program question as it relates to Community CareLink and the Mobile CASE portal. Our partnership with them continues to make the portal better. For example, Randolph County really helped push the need for text messaging and has helped pilot and test changes as we develop them.

The hope is obviously that in coming years, more clients will see the value in offering a portal to their clients so that they can be an active participant in their treatment and recovery.

We wrote a sustainability statement in June 2014 to provide SAMHSA GPOs with more information about our sustainability planning for the TAC grant project, as well as our ideas about the future of this initiative. This sustainability statement is attached.

Status Toward Goals

If you are falling short in meeting any project objectives, please explain and provide your plan for catching up. Include anticipated date of resolution.

We are on track with all project objectives. The only objective that we did not accomplish over the course of this grant was the use of ASI-MV. We built the interface with the hopes of streamlining the use of this for clients who wanted /needed assessment from remote locations but the project did not end up lending itself to that sort of contact with clients. Rather, we engaged with existing clients and used the portal to supplement the treatment services they were receiving. We can utilize the interface in the future based on partner demand. We are also starting to utilize VeaMea telehealth tools to conduct assessments off-site. This technology seems more approachable and comfortable for clients.

Although "engagement" was not an explicit objective, it's worth stating that we fell short in this regard. We succeeded and overcame many barriers to ensure enrollment and the collection of GPRA data for those enrolled. However, we were not able to truly understand the root cause of low client engagement with the portal. It seems that part of the problem has been low enthusiasm from clinicians which in turn lead to low enthusiasm from clients. The other piece may be that rather than a dynamic application that pushed content to users, the portal is a static technology. In the future, this is a major barrier we would hope to address.

If you changed any project goals or objectives (including GPRA targets) during the reporting period, state the changes, the date changes were approved and how the approval was transmitted.

N/A

If you intend to request approval of changes in any project goals or objectives during the next reporting period, state the changes and the reasons for wanting to make them. (Remember that you need prior approval from SAMHSA to make these changes.)

N/A

ORGANIZATION AND MANAGEMENT

Personnel

List all positions supported by the grant, filled and vacant.

Position Title	Incumbent Name	Percent Time
Project Director	Ken Ortbals	25%

Position Title	Incumbent Name	Percent Time
Project Manager	Emily Hage	100%
Director of Programs	Michelle Comtois	20%
IT Developer	Sam Niyazi	100%
Senior Clinician	Keith Faison	57%

List staff additions or losses including contractors/consultants within the reporting period.

Staff/Contractor Position Title	FTE	Date Change Occurred	Addition or Loss
Yvette Williams	Paid on per follow-up basis	May 2014	Loss: support for follow-up GPRAs

Discuss the impact of personnel changes on project progress and strategies for minimizing negative impact.

Ms. Williams no longer had the free time to call follow ups in May so we terminated that working relationship. The project manager, Emily Hage, picked up the task soon after. However, Ms. Hage went on maternity leave mid- June and although clinical staff attempted to keep up with follow-ups, our numbers did suffer as a result of not having a person focused on the task.

Discuss obstacles encountered in filling vacancies (if any); strategies for filling vacancies and anticipated timeline for having positions filled.

N/A

Partnerships

List each of the partner organizations.

Partner
Avenues to Recovery - Olathe, KS
Benilde Hall - Kansas City, MO
Guadalupe Center - Kansas City, MO
Municipal Drug Court - Kansas City, MO
Artists Helping the Homeless - Kansas City, MO
COPS (Counselors Obediently Preventing Substance abuse) - Kansas City, MO
Imani House - Kansas City, MO
Olufemi Sharp - Kansas City, MO
Sarita'Lynne Ministries - Kansas City, MO
Veronica's Voice - Kansas City, MO
Salvation Army ARC - Kansas City, MO
The Center for Healing and Recovery - Raytown, MO

Describe significant changes in relationships and/or working arrangements and summarize the implications of the change

As stated in the last report, we were excited to gain new partners through our KC-ROSC program over the last year. Unfortunatly, the funding for that particular project was not renewed, and as it was a point-of-service payment reimbursement program, those partnerships have not been sustained as strongly as we had hoped. We are still encouraging the use of the CCL software and the Mobile CCL client portal through all these community agencies but we aren't seeing very meaningful use of the portal community-wide, as we had hoped. This goes to a core barrier of the project we've identified: engagement. We worked diligently in conversation, training, etc. to get people at our partner agencies excited about the client portal. We need to back to the drawing board to forge better buy-in.

We received a grant to revive the KC-ROSC initiative here in Kansas City and the Mobile CCL grant will be a vital part of the service delivery model of that project. We are encouraged by the renewed interest in a recovery oriented system of care in Kansas City and hopeful that we can continue to make meaningful partnerships. A core issue is larger than getting partners to use the Mobile CCL portal; it really gets to the point that other community agencies aren't utilizing the Community CareLink software as fully as they could be --they're simply fulfilling a requirement. As we continue to broaden the use and understanding of the CCL software here in KC and in other communities, we might solve some of the engagement issues with the Mobile CCL portal as well.

Training and Technical Assistance (TA)

Describe staff development activities, including orientation and training for this reporting period.

Staff Development Activity	Date	Number of Participants	Training Provider
We planned to hold an MI training this spring but due to large, successful MI trainings in the past 2 springs, we felt the community was at capacity for this particular training. We opted not to offer another MI training.	N/A	N/A	N/A

If you received technical assistance from a SAMHSA TA provider, describe it.

Type of TA Received	Date	Purpose of Assistance	TA Provider	Additional Assistance Planned for this Issue
N/A	N/A	N/A	N/A	N/A

If you plan any training or TA activities for the next reporting period, describe the topic and anticipated audience.

N/A

PERFORMANCE INFORMATION

GPRA Performance

As close to the last day of the reporting period as possible, check your official GPRA statistics on the SAIS webpage. Complete the table below. Enter the cumulative numbers (from beginning of the grant) from the SAIS reports.

Date on which reporting quarter data was obtained: 9/30/2014

	Target	Actual	%
Intakes (Baseline)	*Example: 10* 385	*15* 360	*150%* 93.5%
6-Month Follow	*Example: 0* 316	*0* 203	*0%* 64.2% %

If your intake or follow-up percentages are below 80 percent, please explain and state your plan for reaching your targets.

We had success using a contractor to focus on followups--she was able to make calls outside business hours and clients were receptive to completing the follow up after work or on weekends. However, we had to end that working relationship with Ms. Williams when she found fulltime employment elsewhere. Additionally, the project manager was on maternity leave all summer, leaving other internal staff to juggle the task of follow ups.

Unfortunately due to the large amount of clients enrolled, achieving drastic improvement in our follow-rate became increasingly difficult.

If your count of the number of target or actual persons served (intakes) through your grant or your follow-up rates differ from those shown in your GPRA report, specify and account for the differences. Identify steps taken to seek assistance, if needed, to remedy the discrepancy.

Our GPRA numbers fairly represent people served.

Evaluation

Describe evaluation activities, progress made/action steps, and changes during the reporting period.

Evaluation activities this period consisted of data analysis and reporting. Analyses were conducted on a merged dataset consisting of Addiction Severity Index severity scores, GPRA data, and data describing client access to the technology programming. By merging data we were able to explore evaluation questions related to the utilization and potential benefit of client participation in the technology programming. We were also able to address substance use related outcomes, and the relationship of program participation to those outcomes.

Note any changes to the evaluation plan for this period, and document that GPO approval was received prior to the implementation of the changes.

There were no changes to the evaluation plan for this period

Provide as an attachment the most recent documentation of evaluation findings outside GPRA reporting. Indicate if there are no new evaluation findings from last reporting period.

An evaluation report is attached.

Discuss any problems encountered in conducting the evaluation, the impact of these problems on the evaluation and on the overall project, and plans for resolving the problems.

There were no problems with the project that influenced the evaluation effort. Throughout the course of the project the evaluation staff have experience the project staff as cooperative and collaborative in carrying out the evaluation. The project staff have a sound method for collecting, storing and transmitting data. When evaluation staff have had questions about the data, or required additional data, we always received a response on the same day we made the request.

Discuss how evaluation findings were used to improve the project.

This is the final report. Over the course of the project the staff has been responsive to the findings of the evaluation report. Our initial focus was in providing suggestions for improving follow-up performance. The program has been very effective in that regard. We have also given quite a bit attention to strategies for increasing staff and client participation in the online system. As our evaluation findings indicate, the staff have been effective in increasing participation, although we were challenged to maintain that increase.

Attach any written evaluation reports received during the period. Indicate if there are no new evaluation reports from the last reporting period.

A report is attached.

Interim Financial Status

Attach an updated program budget and any budget modifications.

Report expenditures, not obligations. For instance, if you have a contract with an evaluator for $50, 000 a year, but pay it monthly, report the amount actually paid, not the amount obligated. Note that we are requesting expenditures for the quarter and from the initiation of the grant, not just expenditures this quarter. [In the 'Total Funding' cell, please enter the total amount of grant funding you have received since tile initiation of the grant. For instance, if you are in the second year of the grant and received $400,000 each year, you would enter $1,200,000.] Calculate 'Remaining Balance' by subtracting total cumulative expenditures to date from the total funding amount.

Total Funding*: $800,712		
Expenditures		
Expense Category	Expenditures This Period (4.1.14 - 9.30.14)	Cumulative Expenditures To Date
Staff salaries	$91,036.84	$504,216.79
Fringe	5,575.44	108,709.29

Contracts	32,645.84	92,386.00
Equipment	0.00	0.00
Supplies	0.00	0.00
Travel	0.00	0.00
Facilities	0.00	0.00
Other	30,838.50	95,550.23
Total direct expenditures	$160,096.62	$800,862.31
Indirect costs	0.00	0.00
Total expenditures	$160,096.62	$800,862.31
	Remaining balance	($150.31)
*Total funding should include supplemental awards if applicable, and supplement expenditures should be included in line item amounts.		

Other Significant Project Activities

Discuss any notable project activities, events, or other issues that occurred during the reporting period not previously described. Describe any problems that emerged, the effect it had on the project and steps taken or planned to overcome the barrier.

N/A

Attach a copy of the project's policies and procedures.

See Attachment 1 : Policies and Procedures includes Statements of Informed Consent and Notice of Privacy Practices

Attach copies of any publications in professional journals or presentations about your project during the reporting period. Indicate if there have been no publications or presentations since the last reporting period.

We have not conducted any presentations on Mobile CCL since our last report.

LIST OF ATTACHMENTS

List each attachment separately here and attach to the back of this report.

Attachment 1: Policies and Procedures

Attachment 2: First Call Sustainability Statement, June 2014

Attachment 3: Evaluation Report- October 2014

Attachment 1: Policies and Procedures

STATEMENT OF INFORMED CONSENT FOR PROGRAM EVALUATION

First Call Alcohol/Drug Prevention & Recovery and Mobile CCL project partners including COMBAT Connections agencies support the practice of protecting persons involved in research studies of any kind. You are being asked to volunteer for a program evaluation study of the Mobile MET project. Program evaluation studies are a form a research, and your participation in research is strictly voluntary.

Your participation is voluntary. You can refuse to participate in the study, and there will be no negative impact on your use of Mobile MET, the services you are eligible for, or your experience at any service agency.

Please read this entire form and ask any questions that you may have before agreeing to participate in this study.

Purpose of the Evaluation Study:

There are several purposes of the program and the study. They are:

1) The Mobile MET goal is to improve access to treatment, and to improve the likelihood that those persons wanting treatment will receive treatment when it is available.

2) The project involves linking you with your community service providers via several forms of communication: the web, text messaging, emailing, and web based electronic medical records.

3) The outcomes of the project center on measuring whether or not you are more likely to stay motivated for treatment by using these tools.

4). Evaluation of your satisfaction with the Mobile MET project, and the computer and technology based tools.

All information used for the evaluation of the project will be based on the use of data that does not identify you personally.

Procedure:

You are being asked to participate in the evaluation of your Mobile MET experience, including reporting how satisfied you are with the service. You have the right to refuse to participate in this evaluation—and the services you receive from the Mobile MET project will not be impacted in any way. You may choose to withdraw from the study at any point in time.

If your experience is greater than 12 months, you will be asked to sign these forms again at the end of your Mobile MET experience. You also have the right to cancel your permission to use and disclose any information collected about you at any time. If you discontinue services, we will continue using the information you gave us permission to use. If you cancel permission to use your information, the researchers will stop collecting additional information about you. However, you should know that the research team may have used and disclosed information that was gathered before you decided to cancel.

Community CareLink (CCL) will collect your responses to the following questionnaires and your responses will be used for research purposes:

- **Addiction Severity Index (ASI)—**used for assessment of addiction, and to measure changes in levels of addiction over time. We will ask that you take this assessment at intake, six months, 12 months and at transition points throughout your engagement with services.
- **Client Satisfaction Survey**—voluntary survey at the first transition point (typically at the end of assessment and prior to continuing services), service completion, and at other transition points throughout your engagement with services. It is used to help us measure your experience as a consumer of Mobile MET.
- **GPRA —**survey detailing your demographic, employment, family and other information pertinent to your recovery process.

If you consent to participate in this study we will contact you for a brief interview six months from now. In order for this research to be helpful to others, it is very important that we locate as many of our study participants as possible for the follow-up interviews. For that reason we are asking you to provide information for persons who can assist us in locating you in the event that your contact information changes.

When your follow-up interview is scheduled we will first make every effort to talk with you personally by phone. If you cannot be reached, we will call the contact persons you identify to ask about your current phone number and address. Your contact persons will be told only that the caller is from the Mobile MET project, and we are calling to locate (your name) for a survey in which you agreed to participate. Your contact persons will not be asked to supply any information besides the best way to contact you, and will not be told of your participation in treatment.

Risks and Benefits of Participation:

We do not foresee any physical, psychological, economical, or other known risks to you from participating in Mobile MET or the program evaluation. We believe that having increased access and control over your information, and increased contact with your treatment provider will be helpful to you. However, if at any time you believe that this program is not working for you, you may stop. If you are negatively impacted by the program or the evaluation, we will refer you to and encourage you to seek the appropriate counseling services.

Participating in the Mobile MET project does not interfere with your service at any COMBAT Connections site. The point of this evaluation study is to determine if participating in Mobile MET improves your access to treatment, and your likelihood of receiving treatment once it becomes available. By evaluating the program, we hope to learn about how the program may help others.

Alternatives to Participation:

Your participation is voluntary-and you may end at any time. You may also participate in Mobile MET and choose to NOT participate in the evaluation study.

Revocation:

You may revoke (“take back”) this consent at any time.

Compensation and Cost:

There is no cost to participate. There is no payment for initial assessment/intake evaluation. However, upon the completion of the required six month follow-up interview, Mobile MET clients will be offered a $20 gift card.

Confidentiality:

You should be fully aware of the privacy practices and confidentiality of the community care database before signing this document. The Mobile MET project uses the same community database, and information about you

contained in that database will be available as part of the Mobile MET project. By signing this document, you are stating that you are aware of these policies and practices.

Data for the evaluation will be kept in a secured, locked filing cabinet, in a locked office. In published reports, there will be no information included that will make it possible to identify you as a participant. The electronic records of your participation in the study will be kept on an encrypted hard drive in a locked cabinet in a locked room, with only the researcher having access to them. The information contained in those records will not contain information that could be used to identify you personally.

Data Collection:

You will be asked to complete evaluation tools throughout your engagement with Mobile MET to determine how the program has helped you, and measure your level of satisfaction with the program.

Information already being collected, as part of the Community Care Database, may also be used. Examples of this information include may include treatment participation, substance use, service descriptions associated with community agencies who provided services to you, and information about addiction severity levels. By signing this statement, you are reporting that you understand that information about participation in the project will be shared with the evaluators but information such as name, home address, telephone numbers, or Social Security Numbers will not be included on any records so that you cannot be recognized from the records. All cases given to the evaluators/researchers will contain a special code that allows them to track the cases, and no names or identifying information is used.

PARTICIPANT ASSURANCES:

I understand that my participation in this study is voluntary. I have not given up any of my legal rights or released any individual or institution form liability or negligence.

I understand that I may withdraw from this study at any time without penalty or loss of benefits to which I am otherwise entitled. My treatment and relationship with staff and organizations involved in this study will not be affected now or in the future if I decide not to participate, or if I start the study and decide later to withdraw.

I understand that records of this study will be kept confidential, and that I will not be identifiable by name or description in any reports or publications about this study. I understand that my records are protected under 42 C.F.R.Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”) 45 C.F.R. Pts 160 & 164, State Confidentiality laws and regulations and cannot be released without my consent unless otherwise provided for by regulations. State and Federal law regulations prohibit any further disclosure of such records without my specific written consent or when otherwise permitted by such regulation.

If I have questions about this study, or need to report any adverse effects from participating in the study, I will contact Michelle Comtois, First Call Vice President of Programs and Operations, at 816-361-5900.

INFORMED CONSENT FOR MOBILE MET, ASSESSMENT AND/OR TREATMENT

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in substance abuse evaluation and/or treatment by staff from First Call Alcohol/Drug Prevention & Recovery. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:

    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
    e. Probable consequences of not receiving treatment
    f. Outcomes of diagnostic instruments used in this evaluation

    The evaluation or treatment will be conducted by a certified substance abuse counselor or a licensed therapist or an individual supervised by any of the professionals listed.

2. **Benefits to Evaluation/Treatment:** It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Payment to Mobile MET Participants:** There is no payment for initial assessment/intake evaluation. However, upon the completion of the **required** six month follow-up interview, Mobile MET clients will be offered a $20 gift card.

4. **Charges:** Assessment and treatment services are on a sliding scale and no one is refused services that cannot pay the fee. The fee paid is determined by the business office in consultation with the client, using the Standard Means Chart as a guide. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

5. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record and I consent to disclosure for use by Mobile MET staff for the purpose of continuity of my care. Per Missouri mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

6. **Prohibition against Redisclosure:** Information from my evaluation and/or treatment is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

7. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

8. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

COMBAT-CONNECTIONS NOTICE OF PRIVACY PRACTICES

Effective August 1, 2008

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The COMBAT-Connections is a multidisciplinary collaborative effort designed to enhance sustainability of recovery for substance abusing persons and their families. By coordinating services through the use of a shared web-based tool, the coalition can more effectively and efficiently provide services to those persons and their families. It also assists the participating agencies in the betterment of quality of service by coordinating, delivering, and managing client care through simplified processes and improved communications.

At the core of the COMBAT-Connections is a shared web-based tool that connects the agencies involved to a central data repository. Authorized users will access this tool using a web browser to share a uniform set of personal information (name, nickname, gender). Additional treatment and personal information will be entered into the tool in the event that you receive services at one of the participating COMBAT- Connections agencies. Although this data is being stored in a central data repository, only agencies that provide services to a client will be authorized to view the data and have access to the file. These files will remain locked to all **other** agencies until a client presents themselves for service to a new agency and authorizes the information to be released. Only those individuals authorized by each of the COMBAT-Connections agencies will have access to the information in the shared web-based tool.

As part of the COMBAT-Connections, follow-up health surveys are conducted with clients via telephone six and twelve months after exiting services. Data collected through the surveys is used to help the COMBAT-Connections improve services and treatment for clients in the future.

NOTICE REQUIREMENTS

This Notice explains how agencies participating in the COMBAT-Connections may use and disclose your personal health care and treatment information. Generally, federal and state law requires health care information that identifies you be kept private.[1] Further, the agencies participating in the COMBAT-Connections must give you this information related to their legal duties and privacy practices with respect to any health care information they create or receive about you. The COMBAT-Connections participating agencies are required to follow the terms of the COMBAT Connections Notice of Privacy Practices that is currently in effect.

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in each of the participating COMBAT-Connections agencies. A copy of the current Notice in effect will be available at the receptionist's desk at each of the participating agencies.

This Notice applies only to the personal health care and treatment information that is generated by participants in the COMBAT-Connections and received by the COMBAT-Connections shared web-based tool and database. All references to health information in this document describe information about the treatment and services provided by participating COMBAT-Connections agencies.

[1] The Health Insurance Portability and Accountability Act (HIPAA) of 1996, 42 U.S.C. §1320d et seq., 45 C.F.R. Parts 160 & 164 and the Confidentiality Law, 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2.

Contact: If you have any questions about this notice, please contact the Privacy Officer at (816) 531.7788 for any updated information.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Generally, you must sign a written authorization before COMBAT-Connections participating agencies can share health information about you to anyone outside the agency. For example, we must get your written authorization before we can release information to your health insurer for payment. You may cancel your authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization but we will be unable to take back any disclosures we have already made with your permission, and we are required to retain our records of the care that we provided to you.

Federal law allows us to release information without your written permission for the following reasons:

Business Associates: Some services of participating COMBAT-Connections agencies are provided through contracts with business associates such as accreditation agencies, management consultants, and quality assurance reviewers. We may disclose your health information to these business associates so they can perform the job a participating agency has asked them to do.

Commitment of a Crime. A participating agency may report crimes committed on its premises or against its program personnel, or a threat to commit such crimes.

Suspected Child Abuse or Neglect. We may disclose information about suspected child abuse or neglect to appropriate state and local authorities.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Medical Emergencies. We may provide your medical and treatment information to medical providers responding to your medical emergency.

Required by law: We will disclose health information about you without your permission when required to do so by court order or federal, state, or local law.

YOUR HEALTH INFORMATION RIGHTS

Although your record is the physical property of the COMBAT-Connections participating agency from which you receive services, the information belongs to you. You have the right to:

Copy: Obtain a copy of this Notice of Information Practices upon request.

Inspect: Inspect and request a copy of your health record for a fee. We may deny your request under very limited circumstances. If you are denied access to health information, you may request that another health care professional, chosen by someone on our health care team, review the denial. We will abide by the outcome of that review.

With respect only to the records held by the COMBAT-Connections participating agencies *that must comply with federal HIPAA privacy laws,* you have the right to:

Restriction: Request a restriction on certain uses and disclosures of your information. We are not required by law to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Amend: Request an amendment to your health record if you feel the information is incorrect or incomplete. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. Also, we may deny your request if the information was not created by the COMBAT-Connections participating agency's health care team, is not part of the information kept by one of the participating agencies in the coalition, is not part of the information which you would be permitted to inspect and copy, and if the information is accurate and complete. Please note that even if we accept your request, we are not required to delete any information from your record.

Accounting: Obtain an accounting of certain disclosures of your health information during the six years prior to your request, but not earlier than April 14, 2003.

Confidential: Request communication of your health information by alternative means or locations.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint. This complaint must be in writing to: Privacy Official, COMBAT Jackson Co. Courthouse 415 E. 12th St., 9th Floor, Kansas City, MO 64106 (816) 881-1400 FAX: (816) 81-1416. There will be no retaliation or punishment for filing a complaint.

You also have the right to share your complaints with the Secretary of the Department of Health and Human Services. Secretary, Dept. of Health and Human Services, 200 Independence Ave. S.W., Washington, D.C. 20201 – Phone (202) 619.0257.

Violation of the federal Confidentiality Law by a program is a crime. Suspected violations may be reported to the United States Attorney in your district or the MO-WRO/ Alcohol and Drug Abuse Services.

Attachment 2: First Call Sustainability Statement, June 2014

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(1) A Brief Overview/Update of your Technology Innovation

First Call Alcohol/Drug Prevention & Recovery is grateful for the investment and opportunity provided by SAMHSA's TAC funding program over the past three years. This innovative grant funding helped us build a helpful, client-centered portal for people seeking recovery from substance use disorders. Using the portal, clients can update contact information, send/receive secure messages, view assessment summaries, complete assignments and view/complete treatment plan tasks. This portal, which embraces the principles of Motivational Enhancement therapy, has been successfully used as a supplement to traditional treatment models. The portal has also served well as a mechanism to connect people to the resources they so desperately need via www.mobileccl.org.

(2) A Summary of Goals and Percentage/Level of Accomplishment

Over the past three years, major goals like technology design, development, implementation and support have been managed and successfully completed; the culmination of these goals being the deployment of the Mobile CCL portal. Additionally, First Call has strengthened the clinical capacity of community partners through evidence-based trainings on Motivational Enhancement and Recovery Oriented System of Care (ROSC). These community trainings, along with smartly executed marketing campaigns, have bolstered the outreach and use of the client portal. Since March 30, 2014 there have been 320 enrollees in the project indicating that approximately 29 percent of clients to date have logged into CCL one or more times. The 145 system logins by clients in the most recent six month period were made by 25 different clients. We are confident that more clients will be served as this technology is seamlessly built into our Community CareLink software, enabling any clinician with an interest to utilize the portal with their clients. However, the ultimate goal is a higher level of client and clinician engagement in the Mobile CCL portal.

GPRA Targets (as of May 23, 2014)			
	Target	**Actual**	**Percentage**
Intake	325	331	101%
Follow Up	280	196	70%

(3) Strengths of your Program

Innovative technology, process flow, and scalability are aspects that have all strengthened the success of the Mobile CCL project.

- Innovative technology: The Mobile CCL portal is built within First Call's Community CareLink (CCL) software. The CCL software was certified in October 2013 by the Drummond Group and the Office of the National Coordinator. This certification ensures that the portal was built into a sustainable and rigorous software solution. The portal gives clients the ability to actively participate in their treatment and recovery experience by updating contact information, send/receive secure clinical messages, view/update treatment plan tasks, complete assignments and view assessment summary data.
- Process flow: the first challenge and success of working on the Mobile CCL project was integrating client enrollment and GPRA into the clinical process at First Call and at agencies across the community. By matching the Community CareLink assessment to GPRA questions, it became easy to collect and share GPRA data. By giving clinician's the ability to create a client portal account for the client by collecting an email address and saving a record, we simplified the enrollment process for client's and removed a major barrier to client use of the Mobile CCL portal. Iterative progress was made until a streamlined, intuitive process flow was settled upon.
- Scalability: The Mobile CCL portal is an integral part of the Community CareLink software package now. Communities across the nation are adopting and implementing CCL as their chosen EHR, and the client portal has become an exciting feature rather than just a talking point. For example, a network of agencies in rural Missouri (centering in Randolph County, Missouri) is using Community CareLink to network behavioral health providers and a major part of that project is use of the client portal to engage with clients. Communities continue to see the value in offering client-centered care via technology and any agency that adopts the CCL software can also adopt the client portal to supplement their work.
- Mobility: The Mobile CCL portal is web-based and designed to be accessed from any internet-ready device – smartphone, tablet, laptop or PC. The flexibility of the portal enables clients to use whichever device is best from them rather than dictating the use of a specific, and possibly costly, technology.

(4) Barriers to Program Continuity

When thinking about the Mobile MET project and lessons we have learned over the past three years, two major themes come to mind: engagement and interoperability. Engagement truly applies to both client and clinical users. Clinicians need to see the portal as treatment tool rather than an added step; however, this issue has been an ongoing barrier throughout the grant cycle. A continuation of this project via SAMHSA funding would allow us to ameliorate these specific challenges and enhance the impact of technology assisted recovery.

(5) Action Steps for Ensuring Program Continuity/Sustainability beyond 9/30/2014

Although the portal is sustainable in its current form, we will focus on the core barriers of engagement and interoperability to improve on it in the future. Our current portal is a passive technology which means it is available for client use; however, there is no mechanism in place to actively engage or encourage clients to login. In order to overcome this, we will utilize push technology and focusing on a flexible approach that will accommodate a wider array of users.

An application (app), rather than a web-based portal, is the key to overcoming our past issues with engagement.

As behavioral health joins primary care, the use health information technology will soon require interoperability across technologies. It is not enough to build a portal or an app and keep the data self-contained. We need person-centered apps that feed the EHR; AND interoperability must be a priority to engage with primary health and keep new technologies flexible and salient. The Mobile CCL client portal was built as a window into First Call's Community CareLink software. In the next iteration, we would focus on building an integrative app that also interfaced with the Community CareLink software.

When thinking about what we would need to operationalize this vision, a couple things come to mind:

- Marketing to promote the download and use of the application across a wide range of demographics
- App-savvy software development to ensure ease of use, technical soundness and a professional aesthetic
- Two technology-assisted recovery coaches to support client use of the technology

Thank you so much for the opportunity to express our thoughts in support of the continuation of this funding stream.

Attachment 3: Evaluation Report, October 2014

Mobile-MET TI-023792-01

Evaluating Client Access to the Mobile CCL System

Final Report

October 2014

For this final report we continue to examine program outcomes in terms of post treatment substance use and addiction severity, client engagementment with the Community Care Link (CCL), and the potential role of CCL in supporting treatment participation, completion and outcomes. We also further explored gender differences. Having identified a differential level of exposure to violence in the past report we further inquired into the role of having been subject to violence upon treatment outcomes.

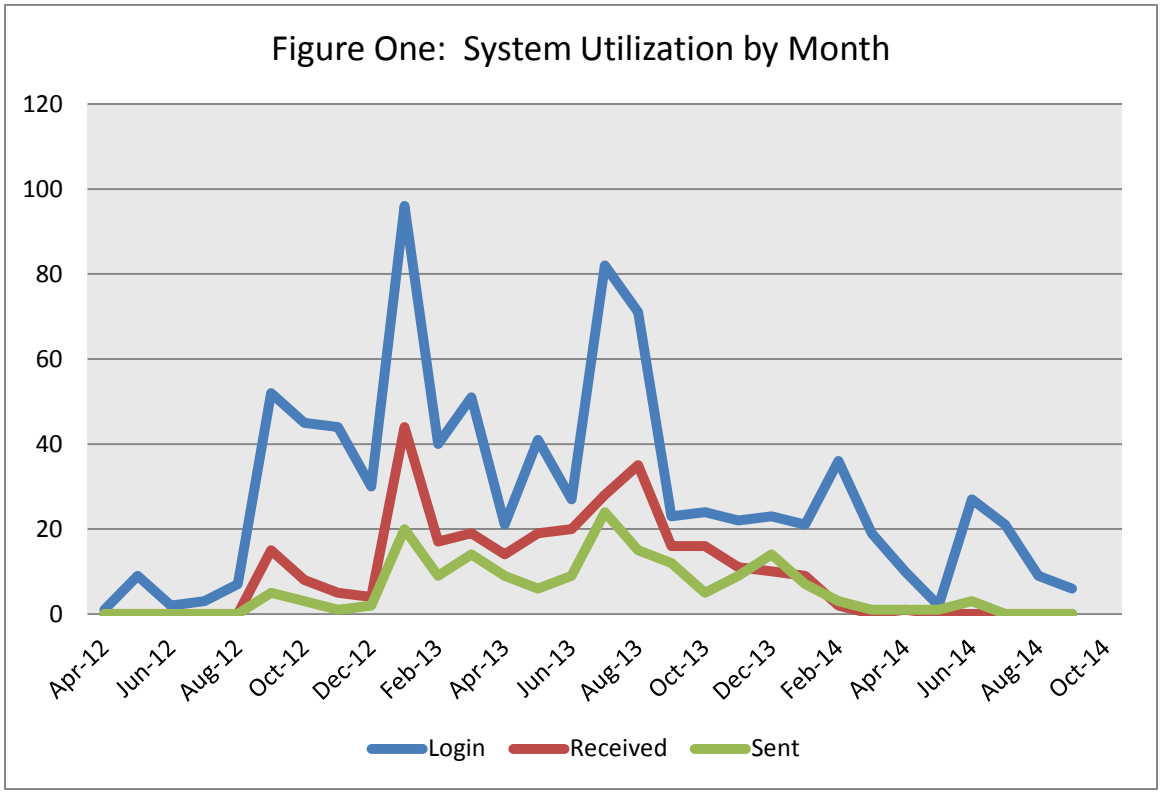
There were a total of 648 interviews conducted at the time of the data pull for this report. Of these, 363 were initial interviews and 285 were follow-up interviews. The data for this report includes GPRA data, intake and six month ASI composite scores, and CCL data on client utilization. The CCL utilization data consists of event level data on client login to CCL, client sent messages to agencies, messages received by client from agencies, and measures of task assignments given to clients via CCL.

CCL System Access

Figure one displays the number of logins to CCL by month from the inception of the project through September 30, 2014. Throughout the course of the project the type of client activity (system login, sent, and received messages) have tended to rise and fall in concert with each other. As we noted in prior reports there were two general periods of high activity with the CCL over the duration of the project. These occurred in the months of January and August of 2013. In interviews with progam staff we learned that these increases followed concerted efforts on the part of program leadership to engage program staff, and to a lesser extent program clients in accessing the system. Given that two efforts to promote use were followed by substantial increases in client and staff activity, it seems appropriate to conclude that when the online progamming was promoted, it was accessed.

However, as system access activity appeared to be a function of encouragement and support from key personnel, it was not sustained in the final grant period. Since those two peaks, system access has fallen off and in the final months of the project returned nearly to the levels observed at project inception. While efforts to increase participation worked, they were not sustained. During that time period the program experienced some significant changes, including a relocation of the agency and some personnel changes. Despite those challenges the program was able to remain successful in enrolling clients and had strong performance in obtaining six month follow-ups over the course of the project.

With respect to CCL access, lessons learned appear to be two-fold. (1) It is possible to achieve sizeable increases in online activity when key personnel embrace the system and encourage use. However, the project was unable to sustain use and build upon successes. (2) Once a client was engaged with the CCL s/he tended to stay engaged. Yet, the system did not appear to have in place the mechanisms to support adoption without consistent recruitment.



Over the course of the project there were a total of 865 system login by clients. In support of the theory that engaged clients remain engaged, these logins were made by 98 unique individuals or 27 percent of the clients who enrolled for services. Of the approximately one in four clients who had a least one login, the mean number of system logins was 9; and 31 percent

of those who logged in at all did so only one time. Most initial logins occurred within just a day or two of entering the program. It appears that obtaining an early login was a good predictor of subsequent participation in CCL.

As has been noted in the past, the vast number of access to the CCL system occurred from clients enrolled in the First Call program, with 68 percent of all enrollees coming from that program. A second program, Avenues to Recovery, accounted for virtually all of the other CCL access by clients and staff. During the final quarter of this project (July 2014 through September 2014), although there was a limited count of system access (n= 35), 91 percent of those cases were from clients enrolled through Avenue to Recovery. Although engagement occurred at fewer agencies that the project might have hoped, two agencies did seem able to maintain a commitment throughout the project.

Characteristics of CCL users and non-users

The question of who accesses CCL has been posed throughout the course of this evaluation with the assumption that these data might inform the program's ability to increase utilization of CCL and to understand client's motivation for making use of it. At least in terms of demographic characteristics there were generally no observed differences between persons who did and did not access CCL. Clients who had accessed CCL one or more times were an average of two years younger (m = 37.0) than clients with no access (m = 39.5). This is not a significant difference (t (358)= .239, p = 0.239). There was no significant difference in income between the two groups (t (356)= -1.03, p = 0.883). Persons who had accessed CCL had a mean monthly income of $1,507 versus $1,558 for those with no history of access. There were also no differences in CCL access by employment status ($X^2(1, N = 359) = 0.31$ $p = 0.576$), gender ($X^2(1, N = 360) = 0.306$ $p = 0.580$), or the presence of a co-occurring mental health problem ($X^2(1, N = 232) = 0.55$ $p = 0.460$). Finally, there was no relationship between an individual's level of addiction severity upon admission and the likelihood of accessing the CCL system during the course of one's treatment experience.

CCL access and follow-up

The opportunity to use CCL to engage with one's treatment provider outside of traditional face-to-face contact has the potential to increase engagement with treatment and potentially influence the programs ability to locate the participant for follow-up. These data allowed us to test that question, and we have explored that in the last few reports.

Over the course of this project the program staff have completed follow-up interviews with approximately 80 percent of the clients who were in the follow-up window. Follow-up interviews were completed with 78.5 percent of CCL users versus 83.0 percent of non-users.

Although an earlier report identified a trend toward finding that CCL users were more readily located for follow-up, this most recent analysis found no significant difference between the two groups ($X^2(1, N = 360) = 0.559$ $p = 0.455$), and although not significantly different the percentage of CCL users who were located for follow-up was, for the first time, lower than non-CCL users. This change is likely related to the general decline in access over the past six months. During the period when clients were more active in the CCL system, clients who accessed were more likely to be located and complete a follow-up interview.

Gender differences

As was observed throughout the project, the program concluded having enrolled a higher percentage of women (54.8 %) than men (45.2 %). There were a number of differences observed between men and women upon admission. Women were significantly less likely than men to report being employed full or part-time at program admission. While 72.7 percent of men reported full or part-time employment, only 56.6 percent of women indicated that they had some measure of employment at the beginning of treatment ($X^2(1, N = 359) = 9.97$; $p < 0.01$).

This difference was lessened at follow-up. Although more men (74.4%) than women (64.3 %) reported full or part-time employment at the follow-up interview, this was a non-significant difference ($X^2(1, N = 359) = 2.47$; $p = .121$). The level of employment of women increased from intake to follow-up.

As noted in prior analyses, a significantly higher percentage of women (75.8 %) reported that they were currently living with one or more children than did men (51.2 %) ($X^2(1, N = 360) = 23.47$; $p < 0.01$). Among participants who reported having children living at home, the median number of reported children was two.

As table 1 indicates, there were other trends in gender differences among this group. Women were, on average, five years older then men at the time of admission. This is a statistically significant difference . There was no difference in total monthly income from all sources (t (358)= -.6222, p = 0.535). However, the amount of monthly income that came from wages was significantly higher among men. Women received a higher proportion of income from public support and other non-employment sources. Given the difference in employment by gender, this finding makes sense.

Women were over twice as likely to have experienced violence prior to entering treatment. Among women, 68.5 percent indicated they had experienced violence prior to treatment as compared to 31 percent of men. Not surprisingly such a large difference is statistically significant ($X^2(1, N = 356) = 16.835$; $p < 0.01$).

With respect to pre-treatment addiction severity, there was no difference by gender in the alcohol or drug severity domain. At admission, women had significantly lower legal severity scores than men. There were also significant differences observed in the family, and psychiatric domains. In these two domains women demonstrated greater levels of severity than men upon admission to treatment.

Table 1: Gender Differences at Program Intake

	Female	Male
Age *	41.5	36.1
Total Income	$ 2,533	$ 2,318
Wage Income *	$1,285	$1,879
Intake Severity Scores		
Alcohol	.071	.093
Drugs	.031	.024
Legal *	.131	.225
Family *	.225	.118
Medical	.131	.082
Psych *	.222	.100
Employment	.465	.450

*

Post-treatment substance use

The data suggest that, on average, persons who participate in the treatment program and follow-up interviews are functioning better at the conclusion of their treatment. At least among the approximately 80 percent of clients who had a follow-up interview, average addiction severity scores were significantly reduced for six of the seven domains (table 2). Only the employment severity index demonstrated no significant change from intake to follow-up. As noted in multiple prior reports, employment severity has remained the highest, or most problematic measure, at both measurement intervals for the entire study period.

Table 2: Addiction Severity at Intake & Follow-up

	Intake	Follow-up
Alcohol *	.093	.032
Drug *	.033	.006
Legal *	.187	.054
Family *	.196	.027
Medical *	.121	.020
Psychiatric *	.194	.111
Employment	.516	.529

*

There was no difference in post-treatment addiction severity by CCL access. Those who accessed CCL reported ASI severity scores that were comparable to those who had not. That finding held even when we controlled for pre-treatment severity *F(*7, 129)=.55, p =0.745; 0.634.

A very high percentage of clients (78.5 %) reported no use of alcohol in the 30 day period preceeding the follow-up interview. However, a fairly high percentage of persons who did drink, did so in a high-risk manner. Among those who reported any use of alcohol in the preceeding 30 days, 27 percent reported having drank to intoxication (five or more drinks on one day) on one or more days. The median number of days of drinking to intoxication during the past month was three days.

Engaging with the CCL system did not appear to have any relationship to post treatment drinking or drinking to intoxication. CCL users reported drinking and drinking to intoxication at the same level of non-CCL users.

Gender and Outcomes

There continued to be a discrepancy between men and women in their income attributed to wages. As table 3 indicates, men reported higher past month earnings than women at the initial interview. The mean reported income by men at intake was $594 higher among than that of women. At the follow-up interview, work related income reported by men was slightly higher than their reported income at intake ($43 per month increase). Although more women reported being employed at the follow-up interview than the initial interview (64 % at follow-up versus 57 % at intake), the mean income for women at follow-up actually declined by $361.

Table 3: Pre and post treatment wage income by gender

	Female	Male
Intake *	$ 1,285	$ 1,879
Follow-up*	$ 924	$ 1,922

*

Both male and female clients who were located for follow-up reported significant improvement in addiction severity from their admission to their follow-up interviews. The pre-treatment gender differences observed in legal, family, and medical severity scores were no longer significant at the time of the six month follow-up interview. The follow-up employment and psych severity scores were significantly different based on gender. In both cases, women had higher severity scores.

Table 4 : Follow-up ASI scores by gender

	Intake	Follow-up
Alcohol *	.035	.025
Drug *	.006	.005
Legal *	.042	.065
Family *	.021	.031
Medical *	.031	.006
Psychiatric *	.135	.078
Employment	.570	.456

*

In addition to bivariate comparisons of gender differences in follow-up addiction severity scores, we conducted a multivariate analysis of variance to assess overall gender differences in addiction severity at follow-up. That analysis found a multivariate effect for significantly greater addiction severity by gender $F(7, 146)=2.55$, $p = .016$. These data suggest generally that women enter the program with greater impairment in key areas, and that while they make significant improvement they conclude the program with greater overall severity.

A very high percentage of clients reported no use of alcohol or other drugs at the time of the six month follow-up interview. There was a slight, though non-significant, difference in reported alcohol use by gender. Among men, 18.7 percent reported using alcohol for one or more days in the preceding 30 days. For women, 25.0 percent acknowledged using alcohol. Days of drug use did not differ by gender for any substance.

We next considered a variety of possible multivariate relationships between the presence of violence, gender, and drinking and drug use outcomes. There was no significant relationship between violence and post treatment alcohol use in any of the binary logistic models that we fit. Gender also did not predict post-treatment use of alcohol. The best predictors of post-treatment alcohol use were a respondent's age, the likelihood of reporting alcohol use increases with age; and the employment and psychiatric severity score. Persons with higher pre-treatment psychiatric severity were more likely to report alcohol use at follow-up. Employment severity worked in the opposite direction, lower scores at intake predicted an increased likelihood of alcohol use.

Conclusion

The program was successful in enrolling and tracking clients. Once the initiative began the program enrolled a steady number of clients over the course of the project. Follow-up interviews occurred very consistently around the 80 percent level for the course of the program. Analyses conducted earlier in this project found no significant difference in follow-up rates by a number of potentially salient characteristics, increasing confidence in follow-up findings.

Persons who were located for follow-up interview appear to have benefitted from their treatment experience. Each evaluation report found a consistent pattern of reduction in addiction severity at follow-up. Relatively small proportions of clients reported any use of alcohol or other drugs in the 30 day period preceding the interview. While both groups improved, the data suggest that women came to the program with more severity in a number of areas, and more economic challenges than men.

Women left the program, improved, but still were not faring as well as men in key areas. Perhaps of most concern, women saw a decline in income earned from work at the six month follow-up even though more women were working at follow-up than at intake. Women were more likely to have been subject to violence prior to enrollment in the program. The presence of violence was related to greater domains of addiction severity, notably, psychiatric severity. That notwithstanding, we were unable to demonstrate that violence played a role upon other treatment outcomes, such as use of alcohol or other drugs at follow-up.

The CCL provided an opportunity for treatment participants to communicate with their treatment provider and to engage in treatment activities such as treatment assignments. However, most program clients never made use of the CCL opportunity. About one in four treatment participants had one or more events in which they accessed the CCL.

Over the course of the project the treatment staff made a number of efforts to increase CCL usage by program staff and clients. At least some of these efforts were informed by interviews conducted by the evaluation team with program staff. There were two big pushes to increase CCL usage, and both were successful. Program leadership had an effective approach to increasing use of the CCL. Unfortunately, and likely for a number of reasons this increases were not sustained.

Perhaps partially because only 25 percent of clients accessed the CCL, we were unable to demonstrate any benefit to client outcomes when contrasting persons who accessed CCL to those who did not. However, clients that did make use of the system tended to continue to use it. While these data do not yield demonstrable benefits, it appears many clients found participating in the CCL to be a useful endeavor.

Tom Gregoire, PhD