ADVANCING RECOVERY COLLABORATIVE

A Breakthrough Series Improvement Project

Final Report

June 2015

CIBHS CALIFORNIA INSTITUTE FOR BEHAVIORAL HEALTH SOLUTIONS | LEADERS IN POLICY, TRAINING, EVALUATION AND RESEARCH

ARC ADVANCING RECOVERY COLLABORATIVE

ADVANCING RECOVERY COLLABORATIVE

TABLE OF CONTENTS

ACKNOWLEDGEMENTS AND PARTICIPANTS

CORE STAFF AND FACULTY

Gloria Frederico
Acting Clinic Director, O.M.I. Family Center

Charles Houston
Social Inclusion Program Manager, Peers Envisioning & Engaging in Recovery Services (PEERS)

Rick Goscha,
Director, Office of Mental Health Research and Training, University of Kansas, School of Social Welfare

Jessica Jones, LMFT, LPCC
Program Administrator, Telecare Corporation

Karin Kalk, ARC Project Director
CIBHS, Associate Director

Sharon Kuehn
Social Inclusion Program Manager, Peers Envisioning & Engaging in Recovery Services (PEERS)

Jerry Langley, ARC Improvement Advisor
Prinicipal, Associates In Process Improvement

Keris Myrick
Executive Director, Project Return

Dave Pilon
President and CEO, Mental Health America- LA

Al Rowlett, ARC Chair,
Chief Operations Officer, Turning Point Community Programs
UC Davis Clinical Professor-Volunteer
CSU Sacramento Part-Time Faculty

John Travers
Director of the MHA Wellness Center, Long Beach

Gitane Williams
Peers Envisioning & Engaging in Recovery Services (PEERS)

Steve Wilson, MD
Medical Director, Telecare Corporation

Mary Wood, MFT, MAC
Regional Administrator, ACT Programs, Telecare Corporation

ACKNOWLEDGEMENTS AND PARTICIPANTS

EXPERT PANEL

Dianne Asher
Project manager for Integrated Dual Diagnosis Treatment (IDDT)
University of Kansas

Marc Bono
Primary Clinician
Turning Point, New Haven CT

Steve Fields
Executive Director
Progress Foundation

Phil Floyd, BS, QMHP, CPRP
Manager, Adult Clinical Support Services
Rockbridge Area Community Services

Rick Goscha
Director
Office of Mental Health Research and Training
University of Kansas
School of Social Welfare

Debbie Innes-Gomberg
District Chief
Los Angeles County Department of Mental Health

Denise Hunt
Consultant

Karen Hurley
Consultant

Renée Kopache
Coordinator of Wellness Management
Hamilton County Mental Health and Recovery Services Board

Sharon Kuehn
Social Inclusion Program Manager
Peers Envisioning & Engaging in Recovery Services

Gladys Lee
CMD Advisory Board

Jerry McCann
Director, Community Services
Momentum for Mental Health

Dave Pilon
President and CEO
Mental Health America- LA

Diane Prentiss
Epidemiologist/MHSA Program Evaluator
Office of Quality Management (OQM)
Community Programs
San Francisco Department of Public Health

Lisa Razzano
Associate Professor of Psychiatry
Dir. of Education & Training Programs, CMHSRP
University of Illinois at Chicago
Department of Psychiatry, Psychiatric Institute
USPRA Chair

Al Rowlett
Chief Operations Officer
Turning Point Community Programs
UC Davis Clinical Professor-Volunteer
CSU Sacramento Part-Time Faculty

Roy Starks
Director of Rehabilitation Services & Reaching Recovery
Mental Health Recovery Center of Denver

Beth Stoneking
PI and Executive Director; Assistant Professor and Director of RISE
The University of Arizona

ADVANCING RECOVERY COLLABORATIVE

FINAL REPORT

INTRODUCTION AND OVERVIEW

> RECOVERY: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." (SAMHSA[1])

The California Public Mental Health System currently serves over 300,000 adults with serious mental illness. While some of these clients are making progress towards having their preferred home, job/education/meaningful activities, and social connections, too many are not. Many cannot easily obtain clinical services when most needed, many leave services having made no progress in their recovery and without hope for a better future; others remain stuck, dependent on the system, and without belief that independence from public mental health supports is even possible. Many factors contribute to this current state:

- Historic beliefs that clients do not recover from mental illness and cannot achieve an independent life with meaningful roles;
- Stigma and discrimination against individuals living with mental illness;
- Lack of person-centered plans and services driven by clients' strengths, goals and aspirations;
- Minimal measurement and use of data for individual clients' recovery assessment as well as system improvement;
- Poor access to services;
- Lack of coordination and integration with the primary care health system and substance use supports; and,
- Payment and compliance systems do not support recovery.

The Advancing Recovery Collaborative (ARC) was undertaken to develop a means by which participating behavioral health agencies could make the profound and essential changes needed to improve the health and wellness of the people they serve. ARC applied the learning from two previous, similarly focused learning collaboratives: "Advancing Recovery Practices" (ARP) and "Improving Capacity and Service Quality" (ICSC). This report summarizes the accomplishments of those agencies and the collaborative learning. It presents a road map for other behavioral health agencies in early stages of designing strategies to advance the recovery and improve the experience of care of individuals with serious mental illness.

[1]Substance Abuse and Mental Health Services Administration. (2011, Dec. 22) SAMHSA's definition and guiding principles of recovery-- Answering the call for feedback [SAMHSA Blog].

Sponsorship and Charge: The California Department of Health Care Services sponsored the California Institute for Behavioral Health Solutions (CiBHS) to conduct this collaborative learning project. From October 2013 and continuing through December 2014, 15 teams from community-based and county operated mental health programs tested and implemented changes that advance the recovery of the clients they serve. The teams, comprised of providers of care, their agency leadership, and client representatives, worked to ensure clients transition to higher stages of recovery and independence from the mental health system, and development of more meaningful, self-directed lives in their communities. As a result of working with clients to improve their health, home stability, purposefulness of daily life, and depth and breadth of relationships in the community, teams endeavored to increase the number of clients served using the same or less funding resources. In summary, teams made changes to improve their organization's quality and effectiveness of services and supports.

Over the course of ARC, teams from Full Service Partnerships, traditional outpatient programs and wellness settings made changes to:

- Build staff belief in and expectations of clients' potential for recovery, independence, and self-sufficiency;
- Promote clients' hope for their recovery and independence;
- Identify and/or develop clients' strengths, and then make them usable;
- Help clients use these strengths in support of their personal goals;
- Expand clients' natural community supports, including peer supports; and
- Increase the rate of clients' transitions into lower levels of care and out of public mental health services.

The entire ARC Charter, which includes a Problem Statement, Aim, Objectives, Goals and Guidance, is provided in Appendix A.

Participating Agencies: Teams from the following agencies participated in ARC:

- Amador County Behavioral Health
- Providence Community Services, STAY Process
- Providence Community Services, Catalyst
- Colusa County Behavioral Health
- Imperial County Behavioral Health Services
- Recovery Center – Adult Services
- Turning Point Community Programs, Integrated Services Agency - Modesto (ISA)
- Mariposa County Behavioral Health Services
- Mono County Behavioral Health
- San Francisco Department of Behavioral Health, Mission A.C.T.

- San Francisco Department of Behavioral Health, Sunset Mental Health Services
- Shasta County Mental Health, Adult Mental Health Program
- Trinity County Behavioral Health Services
- Turning Point Community Programs, Coloma Center

Outcomes: Progress towards shared ARC objectives are described below (see Appendix K for full set of run charts of process and outcome measures).

1. **All clients to achieve at least one short-term goal every month**: Participating agencies reported success in increasing belief among staff for the possibility of their clients' recovery, as well as increased hope in many of the individuals in their target population. They also discovered activities and processes that can reduce this hope and belief, and work in opposition to the desired impact. As such, teams worked to increase those activities that were hope building and change or remove those having opposite impact. This was important progress as it set the stage for subsequent short-term goal achievement.

   While monthly goal achievement was clearly a stretch goal, teams did begin to help find clients' strengths and make them usable. However, as will be discussed at greater length below, setting very short-term goals was a challenging change for teams and as such, limited the level of short-term goal achievement by clients. Further, many teams felt helping their clients to achieve a short-term goal this frequently is unrealistic, likely an indication of both the need to identify smaller, more achievable and meaningful goals as well as the low levels of belief in what is possible for their clients. Future ARC activities will need to find additional means to better address both of these.

   In terms of measurement, the majority of teams found a way to track and report short-term goal achievement, which in and of itself represented an improvement. Their short-term goal achievement results were variable; however, as the overall run-chart for this measure shows in Appendix K - 5, there were the beginnings of an improvement trend towards the end of the collaborative.

2. **At least double the number of clients who successfully transition out of the program each month, including clients who graduate from the mental health system or transfer to a lower level of care**: As seen in Appendix K – 13, progress towards this objective was uncertain. Given the small numbers, both the baseline and normal variation are hard to determine, making changes hard to detect. Further, this change will be the result of a broad set of changes and so will be one of the slowest to be achieved. A longer collaborative is needed to gain the desired results for transitions.

   Early indicators of eventual successful transition are clients' positive changes in Milestones

in Recovery Scale score, a 1-8 scale measuring a combination of engagement, risk/symptoms, and self-management. Appendix K – 8 and 9 show how teams did in this area; several teams do show signs of improvement, others' performance is highly variable, and others is unknown.

3. **All clients experience meaningful activities in their communities every day**: This is also an objective many teams thought was unrealistic; in response, objectives in their individual charters reflected lower targets. Appendix K – 19 suggests a very small upward trend in this area overall, and variable results for individual teams. However, measurement and attention to this area in of itself was useful; it raised awareness that meaningful activities are an important indicator of clients' recovery progress and eventual independence. Helping clients to achieve more meaningful day-to-day lives is a driver in nearly all of the changes ARC presented.

4. A**t least 75% of all clients report that they are satisfied with their housing situation**: As Appendix K – 20 suggests, little progress was made toward this measure, with the overall performance hovering 60% (40% indicating they would like to make a change). Making this inquiry and tracking the response in and of itself was an important improvement teams made. Given the correlation between the quality of clients' recovery progress and their housing situation, tracking it is critical to making recovery improvement possible.

5. **At least 75% of clients participate in paid or unpaid employment**: This is a measure that should grow with short team goal achievement and meaningful activities (see Objectives #1 and #3) and be a reflection of effective development of hope and belief in recovery, as well as use of the strengths-oriented practices to help clients achieve short-term goals. While progress was made in learning how to track this measure, no measureable improvement was achieved overall, although several teams look to be moving in the right direction (see Appendix K – 25 and 26).

6. **At least 90% of clients have a designated PCP whom they've seen in the last 12 months**: As ARC progressed, it became clear that the scope of changes planned was too great for the duration of the project – or the capacity of teams to manage. So increasing PCP designation and access was not directly pursued. However, as Appendix K – 27 shows, there was overall improvement in this area. Several teams already had this capacity and others seemed to develop it during the collaborative. Improvement may be due to the attention paid to PCP status in order to collect and report the data for ARC; alternatively or in addition, this improvement is an indication of the industry-wide recognition of the need for mental health providers to support their clients' access to primary care.

7. **Provide field-based Strengths Model supervision to all front-line staff**: Per the discussion in the section "Agency Progress and Learning – System Supports", this change area was not pursued and so there are no results to be reported. Field supervision requires a restructuring and even expansion of supervision and virtually all teams were not prepared to make those changes and so would not have been able to develop this kind of supervision.

8. **Increase total number of clients served by at least 5-10%**: The lack of improvement in this area correlates directly with the limited improvement in Objective #2 above. This measure will be critical for long-term assessment of improvement, particularly once changes are spread throughout an agency.

Analysis of this learning led project staff to develop the recommendations described below, which are intended to enable over-arching improvements in the next collaborative. These recommendations are discussed at greater length in the final section of this report. Recommendations include:

- Engage leadership from the beginning in their role in advancing clients' recovery and the system changes they will need to guide;
- After the Pre-Work phase, create a 'readiness' phase that is focused on building the supervision/coaching and management capabilities necessary to support the practice changes associated with ARC;
- Engage full teams in change work in the next 'practice change' phase, with prepared supervisors, managers and data gather systems;
- Narrow the scope of changes to a manageable array;
- Introduce focus on access and intake processes earlier, including leadership 'walk-throughs' to gain insight into opportunities for improvement.
- Increase the ability of teams to gather and use data for improvement of individual clients, of populations or groups of clients, and for their systems;
- Reduce the instruction on the theory and history of the Model for Improvement; rather build the improvement methodology into presentation of changes.

METHODOLOGY

Collaborative Processes: The ARC pilot collaborative structure and process was based on the Institute for Healthcare Improvement (IHI) Breakthrough Series (BTS) Collaborative model. Through ARC, the teams participated in five face-to-face Learning Sessions where they were introduced to new ideas. They tested and implemented successful ideas in their settings during the Action Periods, in between learning sessions. They also maintained regular contact with each other and with ARC leadership and faculty through email, conference calls and site visits during the Action Periods. Teams started by testing changes in a smaller target population instead of their entire system. By making changes to practice and sharing their experiences, participants accelerated their learning process and positioned themselves for widespread implementation of successful change ideas.

Key elements of this process that were applied to generate and accelerate improvement and enable participating agencies to expand and sustain them included:

1. Making frontline staff in clinical programs the agents of change instead of the targets for change. This empowered them to take charge of the change process and to monitor its effects on client recovery.
2. Scaling down the size and scope of making change to manageable levels by working with individual or small groups of clients before broader implementation. This allowed the staff to test their ideas and see what worked and what did not work in order to observe and then successfully predict what modifications would result in improvement, not just change.
3. Using data to support improvement efforts and assure that changes made lead to desired improvement.

A more detailed description of collaborative processes is available in Appendix B.

The Charter: Building on the learning from the Advancing Recovery Practices pilot collaborative (ARP), ARC staff and faculty developed an over-arching aim to guide the entirety of the project and assure participating agencies came together around a shared or common aim. This over-arching aim and associated goals were:

> **The aim of the Advancing Recovery Collaborative (ARC) is to** advance the recovery and independence of individuals with serious mental illness**. To accomplish this, ARC will focus on** supporting clients' achievement of short term goals, movement to higher levels of recovery, and overall progress towards the life of their choice**. Over 11 months, t**eams will test and adapt innovative changes that will help people develop meaningful, self-directed lives in their communities with a focus on improved:

- Health,
- Housing,
- Purpose in daily life, and
- Relationships in their community.

Goals

1. Improve the overall emotional and physical health of clients and support their involvement in the management of their own health;
2. Increase the number of clients with a safe and stable home consistent with their individual desires and resources;
3. Increase the number of clients that report a desired sense of purpose in life and the ability to engage in meaningful community activities, (such as a job, school, volunteerism, family caretaking or creative endeavors;
4. Increase their agency's capacity to serve a greater portion of individuals in need in the communities they serve.

While this served as the over-arching aim, teams developed their own versions to more clearly specify their desired improvement and assure appropriate alignment within their agency's strategic priorities. See Appendix C for individual teams' aims and target populations.

As indicated in the Overview, specific goals for all teams were:

1. 20% increase in capacity or total clients served
2. 90% of staff receive routine (weekly) recovery oriented supervision
3. 90% of clients have up to date individual recovery measures (e.g. MORS)
4. 60% increase in supervisors field based mentoring to help staff improve skills related to evidence based and recovery oriented practices
5. 60% increase in supervisors reporting regular consultation with managers re: program data, progress toward improvement goals, and needed resources to achieve the goals

The Change Package: A Change Package is a structured set of evidence-based principles and ideas for improvement and forms the basis for the collaborative content, Learning Session agendas, and Action Period activity. Developed from the learning during ARP and ICSC and with guidance from an Expert Panel, this package contains those ideas considered to be the most valuable and/or necessary changes to achieve the aim.

Beginning at the first Learning Session and throughout the collaborative, testable principles and ideas related to the recovery system supports and client recovery goals were introduced to the teams by expert faculty. Teams were encouraged to test the principles and ideas presented by the faculty, and, as the collaborative progressed, by their peers who had gained knowledge

from their own tests and implementation. The Change Package was refined throughout the collaborative based on what the teams were learning. Appendix D contains the ARC Change Package, which had the following four themes of changes:

- Theme 1: Build Hope and Belief in Recovery
- Theme 2: Identify Meaningful Goals and Strengths to Achieve Them
- Theme 3: Plan to Achieve Goals
- Theme 4: Achieve Goals and Independence
- Theme 5: Design System Infrastructure to Support Individualized Pathways to Recovery

Teams selected which of the high leverage change ideas introduced by faculty and their peer teams they wanted to test, tested them with their target population, reviewed their data over time to see if those changes led to progress toward their goals, and implemented (made permanent) the successful changes based on data from their run charts. All of this prepared teams to spread those changes beyond the target population to their entire organization so that the improvement could be sustained. Note that the work of planning for spread was supported by ARC, however the actual spread work was not (due to time limitations).

The Measurement System: Unlike research or evaluation, the use of measurement in learning collaboratives is specifically to provide feedback on whether improvement is occurring. The learning collaborative measurement system helps teams understand the impact of the changes they made. Two types of reports provide this feedback: monthly narratives and monthly data reports.

The Narrative Report is structured to facilitate recording and tracking of changes being tested, implemented, and spread. They become the diary of the team's collaborative experience, documenting not only the changes they made, but also the learning that occurred.

Data Reports on select measures help teams and project faculty evaluate the impact of changes on the target population. See Appendix F for the full set of measures developed for ARC. Teams used an Excel tool for tracking the measures; they set up the necessary data collection and processes so they could review data frequently and over time (note many teams used the ARC web-based registry to collect their data; see attachment G for the User Guide for this registry, which is a web-based tool developed specifically for ARC). During Action Periods, improvement advisors (faculty with expertise in improvement methods and measurement) coached teams on how to use run charts generated from the data, to annotate their run charts, and to analyze patterns in the data over time.

AGENCY PROGESS & LEARNING

As described above, from January through December 2014, agency teams selected ideas presented by faculty in learning sessions and/or described in the Change Package, and tested them to determine how to then effectively adopt or implement them in their respective environments. Below is a summary of the agencies' learning and results, organized around the themes and change concepts.

Theme 1: Build Hope and Belief in Recovery

Building on the learning from ARP and our experts that hope is a necessary foundation for an individuals' recovery, ARC faculty presented changes in Learning Sessions I and II that help teams to develop belief in and hope for their client's recovery. As with ARP, the learning amongst ARC teams demonstrated that to assure hope is developed and fortified for each client, it must be woven into the fabric of a system and its design. To support this, the change concepts and associated ideas described below (presented by faculty and outlined in the change package) were pursued by teams and seemed, when fully implemented, to be effective at building hope and expectancy of recovery. Following testing and implementation of these ideas, participating agencies reported (qualitatively) increased belief among staff for the possibility of their clients' recovery, as well as increased hope in many of the individual clients in their target population. Doing this work, they also discovered existing activities and processes that reduce or impede development of hope and belief, and so were challenged to change or remove these. As will be discussed below, many of these conflicting activities proved very difficult to alter or eliminate.

Help clients and staff understand that recovery is a possibility for all people diagnosed with serious mental health issues: Applying the change ideas presented in this conceptual area, teams found that finding and sharing stories of successful recovery did help build belief in recovery to a degree. This greater belief was important, in that it created a greater willingness among staff to subsequently try changes during their interactions with individual clients, in particular engaging them in conversations about the kind of future they would like. Sharing success stories and introducing clients to peers who are farther along in their recovery also proved a useful starting point for building belief and making possible subsequent recovery-oriented practices.

Assist each person to discover and express their evolving definition of recovery: Through testing changes intended to help clients discover and express their desired recovery, staff experienced a mixture of successes and challenges. For clients with symptoms well managed and already progressing in their recovery, the changes in approach were fairly smooth and helped to build momentum for even greater recovery. However, for clients with significant

symptoms and/or substance use, staff found these changes difficult and as a result often abandoned them without much experimentation to find nuances in the approach that would work.

Demonstrate organizational belief in recovery: While the changes in the two conceptual areas described above were successful in helping individual staff and clients increase belief and hope in recovery, demonstrating this organizationally proved more challenging for participating teams. Heavy focus, in terms of both management and measurement, on compliance and productivity commonly conveyed the greater organizational priority of these two areas – and implied (unintentionally) a lesser or low importance for recovery. Further these priorities often created conflict for staff, in terms of their time and attention being focused on compliance and productivity versus building hope and belief in recovery. Teams reported that staff often felt they could be compliant and productive OR recovery orientated, but not both.

ARC agency leaders were engaged to address this conflict, although it largely remained unresolved for most teams by the conclusion of the collaborative. Future endeavors will need to find a means to resolve this conflict at all levels of organizations seeking to improve their agencies' ability to advance clients' recovery.

Theme 2: Identify Meaningful Goals and Strengths to Achieve Them

A natural evolution of the promotion and support of hope for recovery is converting that emerging belief into actionability around the specific aspirations, goals and dreams of each client. Identification of these important drivers of change can deepen the level of a client's hope and belief while also strengthening their engagement and readiness for the change activities that help them realize those dreams. This translation starts with the identification of clients' strengths and getting those strengths into their most usable form, and then becomes actionable when providers help clients to use those strengths to progress toward achievement of their goals.

Change ideas related to this theme of goal identification and related useful strengths were presented in three conceptual areas.

Identify clients' usable strengths: In Learning Sessions I and II, teams were instructed on the use of the Strengths Assessment, an evidence based technique developed by Kansas University. Teams received a demonstration of this technique, which in practice is an activity undertaken over time and encompasses an exploration of clients' strengths in seven domains and several temporal perspectives. They learned how to use this approach to both build hope and identify strengths.

As teams began to use this approach with clients, they learned that it often takes several visits with a client to develop, and then remains useful as clients' discover and/or gain new strengths throughout ongoing services. A common challenge or obstacle to the adoption of the technique and tool was the misperception that the objective was to complete the form, and as such was sometimes mistakenly viewed as another documentation burden. Through continued coaching by ARC faculty and local supervisors, teams learned that strengths assessment is an ongoing clinical process and one that can be conducted without the form itself. The greater teams were able to conduct assessments in this vain, the greater their ability to discover clients' strengths.

Another challenge for teams was to learn to move beyond just the identification and documentation of strengths, as they do in the formal initial assessment process required by regulation, and to learn to express those strengths in their most usable, actionable forms. This sets the stage for clients' use of those strengths in pursuit of their goals. This reframing of strengths proved to be challenging for many individuals, especially when their local supervisor was not able to coach the practice change. For others, this shift represented an exciting new way to view their clients and engage with them around a more promising future. Teams found that when they put strengths into their most usable form, they were better able to use these strengths in specific and concrete ways to help a client make progress towards their goals and their overall recovery.

Set and achieve meaningful and important goals using highly individualized and specific strengths: Using the Strengths Assessment techniques, one of the two primary tools of the Strengths Model developed by the University of Kansas, serves multiple purposes. It helps clients understand and engage in recovery. It also supports staff to gain a better understanding of what is meaningful or important to the person, help the client set meaningful and important recovery goals and identify client's strengths (i.e. skills, talents, personal and environmental resources). This sets the stage for identifying specific strategies for goal achievement, and ultimately the amplification of a person's wellness.

This change represented an exciting shift for many teams; by spending time and bringing attention to their long term goals through the lens of their strengths, staff and clients became more hopeful, energized and recovery oriented in their sessions. Teams reported clients being excited and surprised by this shift in conversation and it helped in some cases to move away from an unnecessarily sole focus on crisis and problems.

Align with client to build a collaborative working relationship: With the intention to improve supports for individuals with substance use problems, teams were presented techniques means to apply Motivational Interviewing, including the Importance/Confidence Ruler and the Payoff Matrix. These helped teams to determine if they need to develop discrepancy between a

client's goals and current behavior or support self-efficacy to build a person's internal confidence to change by looking at past accomplishments and applying those to the current situation (e.g. looking at past success and asking the person how they did it). Use of the Pay-Off Matrix is used to understand pros and cons of behavior change. While many teams experimented with the use of these tools, few progressed to the point of incorporating them into everyday practice. Despite their value, low adoption of these tools and techniques may simply have been due to the overwhelming scope of change associated with ARC, an important learning to be addressed in future collaboratives.

Theme 3: Plan to Achieve Goals

The work to build both clients' and staff hope and expectancy for recovery must be followed up by providing appropriate services and supports that help clients to fulfill that hope and progress toward their goals, otherwise the hope goes unfulfilled and can demotivating.

Plan to achieve goals by breaking them into smaller, measurable steps (short-term Identify clients' usable strengths: In Learning Sessions II and III, teams were taught how to use the Personal Recovery Plan (the other of two primary tools of the Strengths Model developed by the University of Kansas) to break client's recovery goals into actionable steps that can be completed each time the worker and client meet together. While the client's treatment plan details the specific goals and objectives that are to be accomplished over a ninety day to one year period, the PRP focuses on the specific tasks that can be accomplished either during a session or between sessions to make progress toward achieving goals and objectives on the treatment plan. Steps on the PRP are part of an organic, iterative process, where next steps are generated depending on the result of the previous steps. The intent is to keep the client engaged in goal-directed activities that supports the accomplishment of something that is important and meaning to the person. Other purposes for the PRP include; the ability to celebrate with the client even small achievement; increase and maintain hope for achievement of goals with lengthier timeframes; take exploratory steps towards goals where the client might have ambivalence or goals that have not been fully clarified; more quickly identify areas where specific barriers are preventing a client from making progress towards a goals and generate steps to remove those barriers; etc.

Pursuit of this change was quite challenging for teams. Most teams were very accustomed to helping their clients' describe long term goals (or desired results); however setting short term objectives steps that were much smaller and doable and also directly tied to usable strengths was a substantial shift and uncomfortable change for many teams. This proved such a new way of approaching clients' goals that this practice change was slow to be adopted regularly, and was rarely ever pursued with clients who were highly symptomatic and/or in crisis. However, when attempted, the approach did begin to bring about the beginnings of a greater focus on

recovery and goal achievement and less on crisis and problems. Making the full shift will require more time, greater local clinical coaching and supervision, and visible, unequivocal support from leadership.

Use stages of treatment scale to guide intervention and evaluate progress: Recognizing that in ARP, few changes were offered to address the challenges of supporting individuals with co-occurring mental health and substance use concerns, ARC several were added in ARC. The use stages of treatment worksheet on a monthly basis to assess where a client is in treatment is an important activity that enables matching of intervention to stage of treatment. The stage of a client is useful in conduct of services, in group supervision leading to brainstorming of stage specific interventions, identifying clients who remain in one stage for a long period of time (to evaluate the effectiveness of current interventions and consider adding new interventions, revising the approach to an intervention, or intensifying services).

While these change ideas were well received by teams and recognized as useful, most teams found they did not have the time and system supports to move beyond testing them.

Use Shared Decision-Making Around the Use of Medications: Another key area that ARP did not address but is clearly a central aspect of recovery supports for clients is the use of medication. In Learning Session IV, teams were provided guidance on how the strengths model approaches can be used to guide shared medication decisions. While some teams had begun to do this already, the value of sharing the Strengths Assessment and Personal Recovery Plan with prescribers and including them in group supervision processes was presented. Teams also learned how to support clients to use their "Personal Medicine" to achieve their goals and advance their recovery, with the recognition that medication is not the only kind of therapeutic 'medicine' that helps clients to advance in their recovery.

Given many of these changes were dependent on having Strengths Assessments and Personal Recovery Plans for their clients, few teams were able to make much headway with this change area. However the thinking around "Personal Medicine" did heighten the awareness of the value of discovering strengths and developing meaningful goals, both of which are central ingredients to this category of 'medicine.'

Theme 4: Achieve Goals and Independence

In Learning Sessions III and IV, as well as associated Action Periods, guidance was shared regarding how to continue the hope-building, recovery-oriented practices throughout the duration of services, at every service – even when there are crises. The tools associated with these activities are intended to be used at each visit to maintain attention to strengths and even build on them as recovery progresses, as well as to revise and add to the Personal Recovery Plan. This essentially represents full adoption of these techniques and would be

evidenced by their use *instead of* less directed, strengths-oriented activities. Full implementation in this vain was not achieved by many teams although for those with strong leadership, management and supervision, it will likely be gained soon after the conclusion of the collaborative. For those without this kind of support, this routine use of the techniques may not be achieved in the near future.

Another scenario also emerged in this theme; that is the use of the tools and techniques only with clients with some degree of recovery already achieved. More symptomatic, unengaged clients were often thought to not benefit from these approaches. In the future, more and different training and support for use of the hope/strengths approaches on more challenging clients will be needed.

Evaluate progress and update the plan at each visit: To support ongoing use of the changes in the previous three thematic areas, faculty provide guidance regarding how to use them at each visit. This include the following processes at each visit: checking in with clients' about where they are in their recovery and achievement of long-term goals and how they feel about their life overall, and also reviewing their goal status. Knowledge gained from these check-ins would be used to revise the Strengths Assessment and Personal Recovery Plan. The duration of the collaborative was insufficient to fully support the learning about how to do this, including how to build in these approaches into everyday practices with all clients.

The Recovery Tracker previously described previously was provided to support this routine process and capture status at each visit. The tool also made it easy to view clients' progress over time. As a new tool, the Recovery Tracker was tested by about half of the teams and four or five began to use it regularly.

While the ARC change package is comprehensive, it proved beyond the scope of the collaborative timeframe. Given teams were not ready to take on more changes, the ideas in the following conceptual areas were only referenced in general:

- **Assist client with obstacle removal and create opportunities for goal achievement at every visit**
- **Make use of naturally occurring resources to help clients connect to their community**
- **Support clients to prepare to and then exit the system**
- **Use self-management strategies to help people progress in their recovery**

Theme 5: Design System Infrastructure to Support Individualized Pathways to Recovery

Provide leadership for recovery: Leadership involvement in the work to test and implement changes that generate hope and expectation for recovery is one of the most important

ingredients for successful change. Both senior executives and program managers have critical roles in the improvement work. Teams whose directors and program managers were actively involved in ARC pursuits, from team meetings to learning sessions to action period calls, made the most progress. The quality of this leadership is also important; disempowered program managers and/or team leads led to disempowered and pessimistic teams. Actual participation and active backing of program managers provided the most reliable empowerment and prospect for success, even when senior management was less involved. Individual leaders also supported their ARC teams to present their ideas and associated improvement at a variety of agency-wide activities, including recovery celebrations, which both reinforced the agencies' commitment to supporting hope for recovery and as well as set the stage for spreading the changes through their organizations.

Organizing leaders from participating agencies in monthly collaborative conference calls was an effective strategy to engage and support their involvement in their team's improvement efforts. However, the duration of the collaborative was not sufficient to fully address the seemingly competing priorities of compliance/productivity and recovery-oriented practices. Further, future collaboratives will need to begin addressing this during pre-work with even more clear means of making changes that advance clients' recovery AND achieve required organizational compliance and productivity.

Integrate recovery orientation into routine operations and daily management: As suggested in several of the descriptions above, building recovery orientation into daily routines is critical to sustaining the changes promoted by ARC – and to reliably being able to advance clients recovery. While some teams began to achieve this by moving away from non-recovery oriented activities and replacing them with the ARC approaches, many teams found they were trying to add these activities on top of existing. This resulted in unmanageable operations, with the previous activities remaining priority and the new processes undertaken when time allowed. However, the increased focus on recovery was starting to influence many existing activities (e.g. approach to new hire training, staff meetings, etc.) and so there was promise that fundamental shifts were coming.

One prominent challenge that will need additional clarity and attention in future collaboratives is marrying the recovery approaches with standards of medical necessity. Despite providing specific coaching and written guidance to achieve this blending, many teams continued to struggle, with staff feeling uncertain that ARC approaches would not result in audit findings.

Alternatively, one area of great progress was in the training and use of MORS, or the Milestones of Recovery Scale. The Milestones of Recovery Scale (MORS), which quantifies the stages of an individual's recovery using milestones that range from extreme risk to advanced recovery and everywhere in between, is an effective evaluation tool for tracking the process of recovery for

individuals with mental illness. It can help staff tailor services to fit each individual's needs, assign individuals to the right level of care and create "flow" through a mental health system. When consistently applied, MORS allows useful client and population tracking and targeted support of recovery. Key variable to successfully adopting the MORS included: accessibility of data over time, use in individual and group supervision, ability to aggregate data to target specific populations.

In addition to using assigning clients a MORS score at regular intervals, several teams also reviewed MORS measures in team meetings to better understand and become aware of where clients were currently at in their recovery and start the process of monitoring how clients progressed in their recovery over time. Several teams also found value in MORS when via identification of clients who are stuck at a particular level, especially MORS 5. Several found a correlation between this persistence at the same recovery level with their living situation – particularly when the housing was in Board and Care settings. This enabled teams to think about how to support this sub-population in new and useful ways, rather than letting the status quo persist.

Provide clinical mentoring/coaching and skill development that support clients' recovery progress: The ARC change package describes two types of strengths–based coaching: strengths based group supervision and field mentoring. Few teams were ready to pursue field mentoring and so it was only offered selectively. Alternatively, group supervision was a big focus in Learning Sessions I, II and III and proved an invaluable change for all teams.

Strengths-based group supervision, also developed by the University of Kansas, School of Social Welfare, Office of Mental Health Research and Training, provides a process for group supervision sessions that directly impact progress of client goal achievement, with particular attention to use of client strengths to develop highly individualized strategies. In its most frequent form, strengths-based group supervision involves a team of practitioners (usually four to seven), their supervisor, and at times, specialists (e.g., medical personnel, vocational staff, substance abuse experts, etc.), family members or key support (e.g., friend, minister, and employer).

Most teams found that they were able to redesign a current team meeting to accommodate the Strengths-based Group Supervision process rather than create an additional meeting. Most teams found that it took a few months of diligently following the steps of Strengths-based Group Supervision before it became a routine process of how they conducted these types of meeting.

Field mentoring is a supervisory method used to help staff further develop and refine their use of skills and/or tools in actual practice. Field mentoring, as designed by the University of

Kansas, School of Social Welfare, Office of Mental Health Research and Training, follows a structured process that begins with an agreement between the supervisor and the staff person identifying the specific skill the staff person would like to learn or gain proficiency. Learning takes place in an actual work setting with a client, for whom using this skill would benefit the client in their own course of treatment and/or achievement of goals. The client should be aware that a field mentoring session is occurring and be included in the learning by sharing their experience of how what occurred was helpful or not helpful to him/her. Substantial testing is required to both learn how to conduct filed mentoring and also to build it into supervisor's schedule and responsibilities. As already mentioned, teams did not have the readiness to support this change and so it was not presented or pursued.

Future collaboratives will need to work with leadership and management to find ways to support field mentoring, a critical coaching process for organizations aiming to reliably advance their clients recovery.

Develop and support effective use of peer supports (employed and volunteer) for clients at different stages of recovery: The value of peer supports in advancing an individual's recovery is well-established, although often it is only offered sporadically and with little structure or design. In Learning Session II, faculty presented a variety changes teams could make to improve the effectiveness of existing peer supports and create new. Many teams began using peers during the intake process to help build hope and belief, as well as create a more welcoming experience for new clients. Some also began including peer supporters in strengths-based group supervision activities. In general, teams recognized the value the peer supporters in terms of hope building, finding creative ways to utilize clients' strengths and progress towards goals, and in general improve clients' connection to their communities. Even with pre-existing peer supports as well as those developed during ARC, this area remains under-developed and full of potential.

Involve peers in system design and improvement: Also during Learning Session II, teams were provide change ideas about how to engage peers in system design and improvement areas. Given several teams include peers in their ARC teams, some change work happened via the collaborative. However most teams did not have the authority to expand peer involvement in to other areas and so proved to be out of the scope of their ARC work.

Make access and transitions easier and responsive to clients' goals: ARC activities directed at making access to services easier proved one of the most valuable to teams and instructive to future collaboratives (it should take place very early in, if not at the outset of the learning process). Late in the project, senior leadership from each team was asked to walk-through their system's new client intake process. These walk-throughs revealed many compliance-related activities that were not useful to clients and caused great deal in access to the services being

sought. Most found that the process simultaneously confusing and off-putting – and provided insight into high no-show rates for second and third visits. This learning mobilized teams and their leaders to quickly make changes to their intake activities, as well as begin to look at their system through a more recovery-oriented lens.

RECOMMENDATIONS

While participating teams learned how to make changes to create "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" for each of their clients, the ARC project staff gathered knowledge about how to more effectively support this complex pursuit. This learning was in four primary areas: aim (Charter), technical content (Change Package), measurement (Core Measures) and collaborative processes and activities (Timeline and Project Support).

Analysis of this learning led project staff to develop the recommendations described below, which are intended to enable over-arching improvements in the next collaborative. Recommendations include:

- Engage leadership from the beginning in their role in advancing clients' recovery and the system changes they will need to guide;
- After the Pre-Work phase, create a 'readiness' phase that is focused on building the supervision/coaching and management capabilities necessary to support the practice changes associated with ARC;
- Engage full teams in change work in the next 'practice change' phase, with prepared supervisors, managers and data gather systems;
- Narrow the scope of changes to a manageable array;
- Introduce focus on access and intake processes earlier, including leadership 'walk-throughs' to gain insight into opportunities for improvement.
- Increase the ability of teams to gather and use data for improvement of individual clients, of populations or groups of clients, and for their systems;
- Reduce the instruction on the theory and history of the Model for Improvement; rather build the improvement methodology into presentation of changes.

RECOMMENDATION #1 – Charter: As stated previously, project staff with the help of experts developed a project charter. During the final harvest session, collaborative teams were asked how the pilot charter could be improved to better support and guide future endeavors with comparable hopes. While the initial charter provided the general guidance and direction needed for the collaboratives, some shortfalls were identified and resulted in a revised aim which is simpler and more compelling, and is hoped to better engage both leaders and staff (see Appendix L for the complete revised charter):

> ***The aim of the Advancing Recovery Collaborative (ARC) is to*** *advance the recovery and independence of individuals with serious mental illness****. To accomplish this, ARC will focus on a strengths based approach to*** *supporting clients' achievement of short term goals, movement to higher levels of recovery*

(transitions to lower levels of care), and overall progress towards the life of their choice. ***Over 18-24 months, t****eams will test and adapt innovative changes that will promote individuals' ability to develop meaningful, self-directed lives in their communities with a focus on improved:*

- *Health and wellness*
- *Housing*
- *Self-empowerment (Purpose) in daily life*
- *Relationships in their community*

RECOMMENDATION #2 – Change Package: Based on the learning associated with the change package, it is recommended that a simpler, sequenced change package be developed with changes should be structured around the following themes in the following order:

- Build Hope and Belief in Recovery
- Identify Meaningful Goals and Develop a Plan to Achieve Them
- Achieve Goals and Advance Recovery

The above changes would be presented and supported in a 'practice change' phase. The following change theme would be the focus of the initial 'readiness' phase and would be continued throughout the collaborative to insure that the infrastructure changes needed to support the practice changes are made:

- Create Organizational Readiness to Advance Individuals' Recovery

See Appendix M for the proposed change package.

RECOMMENDATION #3 – Measurement: To improve team's ability to collect and use data for improvement, it is recommended that preparation for and initiation of actual data collection begin earlier to enable greater levels of measurement. Activities associated with this recommendation include:

- Develop a set of no more than six to eight core measures, all of which the participants will be expected to collect and report. In addition, the use of team specific supplemental measures will be supported by faculty;
- During Prework, provide access to and training in the use of the web-based registry that was pioneered in ARC;
- Start the improvement project related measurement during the Prework phase;
- Help organizations look at and use their data (not just ARC data) plotted over time; and,
- Integrate the improvement measures into the leadership Prework discussions and help leaders connect these measures to their organizational strategies.
- Create a story or illustrative explanation for each measure to help participants understand their value;

A revised set of Core Measures is also recommended (see Appendix N).

RECOMMENDATION #4: Collaborative Activities & Processes: Study of the recently concluded ARC collaborative revealed many changes to learning collaborative execution that may increase level of participants' improvement and progress toward their aim, goals and objectives. The following recommendations, organized by collaborative phase, address processes that directly impact participants' experience, as well as those internal or behind the scenes, and so are intended to increase the efficiency, effectiveness and satisfaction of core team and planning group members.

Pre-Work: The following modest adjustments are recommended:

- Gather initial data for core measures;
- Prepare for use of the Recovery Tracker (HIPAA clearances, web-access and account set-up, staff training); and,
- Walk-through of the initial intake process by leadership.

These changes are recommended, along with continued use of the standard approaches delineated by the BTS established methodology (e.g. use of a pre-work manual, collaborative calls to support pre-work activity, etc.). They should also be incorporated into the pre-work manual content.

Learning Sessions/Action Periods: The following adjustments to the conduct of learning sessions and action periods are recommended:

- Create two phases:
    - Readiness Phase: Participating agencies organize local ARC Team supervisor(s), manager(s) and leader(s) make system changes necessary to support practice changes associated with ARC (6 months; two learning sessions)
    - Practice Change Phase: Teams are expanded to include frontline staff who will learning practice changes associated with ARC (9 months; three learning sessions)
- Support all faculty to clearly present change concepts and ideas, including a simulation exercise to be completed in the learning sessions and at least one example PDSA for each idea presented
- Conduct regular specialized calls for the following team members:
    - Senior leaders (monthly)
    - Team & data leads (monthly)

In summary, these recommendations are intended help future collaborative participants to gain at least as much improvement, if not more than, the ARC teams.