



ADVANCING RECOVERY PRACTICES

A Breakthrough Series

Collaborative

Final Report

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Executive Summary

The California Public Mental Health System currently serves over 300,000 adults with serious mental illness. While many of these clients are progressing towards having their preferred home, job/education/meaningful activity, and social connections, far too many are not. Many leave services unchanged 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. The Advancing Recovery Practices (ARP) pilot collaborative, sponsored by the California Department of Health Care Services, 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. From January 2012 and continuing through January 2013, 15 teams from community-based and county operated mental health programs tested and implemented changes that advance the recovery of the clients they serve.

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

- Staff belief in and expectations of clients' potential for recovery, independence, and self-sufficiency;
- Clients' hope for and engagement with activities supporting their recovery and independence;
- Clients' natural community supports, including peer supports;
- Use of recovery oriented assessment tools to identify and make use of clients' strengths in support of their personal goals;
- Clients' management of their conditions and personal goals, and;
- Rate of clients' transitions into lower levels of care and out of public mental health services.

OUTCOMES

Participating agencies undertook a wide array of changes to improve client recovery and flow; changes with the greatest impact included:

- **Increasing by leadership and management focus on clients' strengths and successes, staff belief in and hope for their clients' recovery, and promotion of clients' independence and community integration.**
- **Using the Strengths Assessment to help build hope among staff and clients, as well as to identify and pursue clients' goals.**
- **Using strengths-based supervision to advance staff's recovery skills, keep their focus on clients' strengths and goals, assure services are matched to need, and guide clients' progress through the system.**
- **Using recovery measures to support individual and population improvement.**

The single greatest differentiator of level of actual improvement amongst teams was the level and range of leadership – at the executive/senior, program and team levels. The larger and more consistent a senior leaders’ involvement in and understanding of team’s improvement activities, the greater the team’s improvement and the agency’s prospect for successful spread. Program managers who regularly participated in learning sessions, action period calls and team meetings were best able to support the learning through testing and thoughtful shift into implementation. Project team leads who were well supported by program management had the most success in their challenging role of orchestrating a portfolio of changes.

Learning to use data to support improvement was woven throughout ARP’s collaborative work; in turn, effective use of data was a key indicator of a team’s level of improvement. Teams who regularly measured and tracked clients’ level of recovery were better able to match service to needs and goals – both for individuals and groups of clients with similar needs. Teams with the greatest improvement became adept at planning to collect data needed to gain the desired knowledge from tests of change, and then effectively gather, study and use the data collected. While several teams were able to collect data for the core system-level measures used by all teams for the duration for the project, several were not able to sustain the reporting and a few were unsuccessful with virtually all measures. Regardless, the usefulness of the core measures proved quite limited, even for those who were able to gather the data each month. Much work remains to provide future collaborators with highly useful measures.

The engagement of staff throughout the work of ARP was also critical. Teams demonstrated that one of the most effective ways to engage staff was to support their individual discovery of the value of a given change. Self-discovery was just one of the benefits of involving staff in the project team and actual changes processes. Another was making them the drivers of the change and discoverers of system changes that work, versus simply the passive (and likely otherwise reluctant) recipients of those changes.

All of the changes that generated improvement also enhanced the therapeutic relationship between clients and service providers. While this was not consciously attended to in all ARP activities, teams with successful changes consistently advanced the quality and effectiveness of those relationships.

RECOMMENDATIONS

Upon study of what did and did not prove useful for ARP collaborators, the following recommendations are offered to help future collaborative participants to gain at least as much improvement, if not more than the ARP teams.

#1 – Charter: 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:

Through a collaborative learning process, behavioral health programs will make fundamental changes that promote recovery for individuals with serious mental illness, including those with co-occurring substance use and physical health disorders. These innovative changes will help people to develop meaningful, self-directed lives in their communities with a focus on improved: health, housing, purpose in daily life, and, relationships in their community.

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

- Build hope and belief in recovery;
- Get strengths in their most usable form to achieve goals;
- Plan to achieve goals; and,
- Work to achieve goals.

Introduced throughout these themes would be changes to support processes to ensure clients' movement through services: including:

- Measurement of recovery progress and quality of helping relationship;
- Strengths-based group supervision and field mentoring; and,
- Performance feedback and skill development.

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

- During Prework, give the participating teams a data collection form and electronic tool for collecting raw data and provide training;
- Start the improvement project related measurement during the Prework phase;
- Help organizations look at and use their data (not just ARP data) plotted over time; and,
- Integrate the improvement measures into the leadership discussions at the organization.

#4: Collaborative Activities & Processes: To increase the level of participants' improvement and progress toward their aim, goals and objectives, a series of changes to collaborative activities and processes are also recommended:

- Help key team members and leaders to prepare for their team's improvement work, including specific pre-work assignments and participation in special (virtual) sessions;
- Provide a better narrative reporting tool (to improve the quality of reporting of what was tested, what was learned and what action will follow) and support team leaders to complete the tool in a useful way; and,
- Conduct regular specialized calls for the key team members, including senior, team and data leaders.

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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." (SAMHSA¹)

The California Public Mental Health System currently serves over 300,000 adults with serious mental illness. While many of these clients are progressing towards having their preferred home, job/education/meaningful activity, and social connections, far too many are not. Many leave services unchanged 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 against individuals living with mental illness;
- Lack of person-centered plans and services driven by clients' goals and aspirations;
- Limited array of interventions, services and supports for individual clients;
- Poorly defined continuum of recovery services which lack naturally occurring community supports;
- Minimal measurement and use of data for recovery assessment and improvement;
- Lack of coordination and integration with the primary care health system; and,
- Continuing fiscal challenges in a difficult economic landscape.

The Advancing Recovery Practices (ARP) pilot collaborative 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. This report summarizes the accomplishments of those agencies and the collaborative learning that was generated. 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.

Sponsorship and Charge

The California Department of Health Care Services sponsored the California Institute for Mental Health (CiMH) to organize this collaborative endeavor. From January 2012 and continuing through January 2013, 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 clients, worked to ensure clients transition to higher stages of recovery, increase their independence from the mental health system and develop more meaningful, self-directed lives in their communities. As a result of working with clients to improve their

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

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 not only improve their organization's person-centeredness and the quality of the clinical services, but also to increase the public mental health system's capacity.

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

- Staff belief in and expectations of clients' potential for recovery, independence, and self-sufficiency;
- Clients' hope for and engagement with activities supporting their recovery and independence;
- Clients' natural community supports, including peer supports;
- Use of recovery oriented assessment tools to identify and make use of clients' strengths in support of their personal goals;
- Clients' management of their conditions and personal goals, and;
- Rate of clients' transitions into lower levels of care and out of public mental health services.

The entire ARP 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 ARP:

- Anaheim Outpatient-Orange County Health Care Agency Behavioral Health Adult Outpatient Clinic (OCHCA)
- Caminar Wellness & Recovery Services, San Mateo (Caminar)
- Didi Hirsch Mental Health Services, Los Angeles (Didi Hirsch)
- El Dorado County Health & Human Services (El Dorado)
- Fresno County Department of Mental Health (Fresno)
- University of CA, San Francisco/Citywide Forensics, San Francisco Community Behavioral Health Services (SF FSP)
- Humboldt Department of Health & Human Services (Humboldt)
- Kedren Mental Health Organization, Los Angeles (Kedren)
- Mental Health Association of Orange County, Lake Forest (MHA LF)
- Monterey County Behavioral Health Services (Monterey)
- Providence Corporation, Opportunity Knocks, Orange (OPK)
- Narvaez CalWorks-Santa Clara Mental Health Department (Narvaez)
- San Diego County Behavioral Health (San Diego)
- San Mateo County Behavioral Health & Recovery Services (San Mateo)
- OMI Family Resource Center, Community Behavioral Health Services, San Francisco (OMI)

Brief descriptions of these agencies are provided in Appendix B.

Outcomes

Participating agencies reported improved client recovery and flow resulting from the ideas they tested and implemented. Activities with the greatest impact are described below:

1. High Leverage Changes: While many changes pursued by teams generated improvement, several stood out as having considerable impact as they could be applied in all four thematic areas of change. Teams who pursued the following changes made the most progress toward their aims and set the stage for both sustaining and spreading recovery practices and improved client outcomes.

- Increasing leadership and management focus on clients' strengths and successes, staff belief in and hope for their clients' recovery, and promotion of clients' independence and community integration.
- Using the Strengths Assessment to help build hope among staff and clients, as well as to identify and pursue clients' goals.
- Using strengths-based supervision to advance staff's recovery skills, keep their focus on clients' strengths and goals, assure services are matched to need, and guide clients' progress through the system.
- Using recovery measures to support individual and population improvement.

2. Leadership Involvement and Support: The single greatest differentiator of level of actual improvement amongst teams was the level and range of leadership – at the executive/senior, program and team levels.

- Executive Leaders and Senior Management: The larger and more consistent a senior leaders' involvement in and understanding of team's improvement activities, the greater the team's improvement and the agency's prospect for successful spread. The most important leadership activities typically were the removal of obstacles to improvement and creation of a culture of experimentation.
- Program Management: Program managers who regularly participated in learning sessions, action period calls and team meetings were best able to support the learning through testing and thoughtful shift into implementation. Teams with distant program management struggled with advancing their tests to the achievement of predictable results.
- Team Leads: Project team leads who were well supported by program management had the most success in their roles. Management of improvement initiatives like ARP is challenging and requires both project management skills and time for the actual management. Future collaboratives should be structured to support more of both for team leads.

Outcomes

1. *High Leverage Changes*
 2. *Leadership Involvement & Support*
 3. *Use of Data and Measurement*
 4. *Engagement of Staff*
-

3. Use of Data and Measurement: Learning to use data to support improvement was woven throughout ARP's collaborative work; learning to effectively use data was a key indicator of a team's level of improvement.
 - Client and Population Information: Teams who regularly measured and tracked clients' level of recovery were better able to match service to need/goal – both for individuals and groups of clients with similar needs. These teams were able to recognize when clients were not progressing and also identify and reinforce when clients were making progress – and in both cases, adjust services accordingly. Those teams who consistently gathered and used data over time were usually supported by a strong data lead who was a member of the improvement team and able to provide technical assistance throughout the duration of the project.
 - Qualitative and Quantitative Information from Testing: One of the most challenging uses of data is associated with qualitative and quantitative data from testing. Improvement is accelerated when tests of change are based on a theory, have predictions of what will happen, and a plan to collect data from each test. To fully realize the value of the test, the data must be gathered, studied and then used in future tests. Teams with the greatest improvement became adept at planning to collect data needed to gain the desired knowledge, and then effectively gathering, studying and using the data collected.
 - System Level Measures: System level measures were an important, although not central, part of ARP. While several teams were able to collect data for the core measures used by all teams for the duration for the project, several were not able to sustain the reporting, and a few were unsuccessful with virtually all measures. Regardless, the usefulness of the core measures proved quite limited, even for those who were able to gather the data each month. The learning associated with using data for improvement was valuable, however the set of measures provided by the ARP Core Team will need substantial reworking to successfully support the work of advancing recovery.
4. Engagement of Staff: The engagement of staff throughout the work of ARP was critical.
 - Self-Discovery: Teams demonstrated that one of the most effective ways to engage **staff was to support their discovery of the value of a given change. This was** particularly evident with teams who tried changes on themselves before using them with clients.
 - Participation in Project Teams and Change Processes: Self-discovery was just one of the benefits of involving staff in the project team and actual changes processes. Another was making them the drivers of the change and discovery of system-level changes that work, versus simply the passive (and likely otherwise reluctant) recipients of the change.
 - Critical Role of Therapeutic Relationships: The import of the therapeutic relationship was very clear with the work of ARP teams. All of the changes that generated improvement, intentionally or otherwise, enhanced the relationship between clients and service providers. While this was not consciously attended to in all ARP activities, teams with successful changes consistently advanced the quality and effectiveness of those relationships.

Methodology

Collaborative Processes

The ARP pilot collaborative structure and process was based on the Institute for Healthcare Improvement (IHI) Breakthrough Series (BTS) Collaborative model. Through ARP, 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 Action Periods. They also maintained regular contact with each other and with ARP leadership and faculty through email, conference calls and site visits during the Action Periods, a name that clearly discriminates a learning collaborative from a workshop or continuing education event. 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:

- 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.
- 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.
- 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 C.

The Charter

ARP 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 objectives were:

Within the next 12 months, [15] teams consisting of community-based and county operated mental health programs serving adults and older adults will make changes to ensure their clients achieve recovery as defined by SAMHSA². The teams, comprised of providers of care, their agency leadership and clients, will ensure clients transition to higher stages of recovery, increase their independence from the mental health system and develop 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 will increase the

²Substance Abuse and Mental Health Services Administration. (2011, Dec. 22) SAMHSA's definition and guiding principles of recovery-- Answering the call for feedback [SAMHSA Blog].

number of clients served using the same or less funding resources. In summary, teams will make changes that will not only improve their organization's person-centeredness and the quality of the clinical services, but also result in an increase in the public mental health system's capacity.

- 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;*
- 3. Increase the number of clients that report their life has purpose and they engage in meaningful daily activities, (such as a job, school, volunteerism, family caretaking or creative endeavors), and the independence, income and resources to participate in society;*
- 4. Increase the number of clients living in their community who have self-identified relationships and social networks that provide support, friendship, love and hope*
- 5. Increase agency capacity to serve a greater portion of individuals in need in its community*

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 B for individual teams' aims.

The goals of the ARP collaborative were divided into two topical areas: *improving recovery support systems* and *improving clients' recovery*.

This enabled teams to qualify their involvement and efforts as two Performance Improvement Projects (one administrative and one clinical) by California's Mental Health External Quality Review Organization.

Goals for Improving Recovery Support Systems

- 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*

Goal of Teams

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 will increase the number of clients served using the same or less funding resources. In summary, teams will make changes that will not only improve their organization's person-centeredness and the quality of the clinical services, but also result in an increase in the public mental health system's capacity.

Goals for Improving Clients' Recovery

1. 100% increase in number of clients who transition to higher stages of recovery
2. 50% decrease in clients who leave service within 6 months without goals being met and not engaging with public mental health services
3. 25% increase in the number of clients reporting they are living in their preferred home for more than 6 months
4. 95% increase of clients that express their treatment plan has goals (hopes and dreams, not just symptom management) that are important to them
5. 40% increase in the number of days clients are engaged in meaningful community activities that provide them with a purpose and role, regardless of recovery
6. 100% increase in number of clients who transition from the public mental health system, no longer need case management services, and are living a meaningful life in the community with natural supports in place
7. Reduce by 50% the number of clients who are 5150'd³

The Change Package

A Change Package is a catalog of evidence-based principles and ideas for improvement and forms the basis for the collaborative content, Learning Session agendas, and Action Period activity. 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 ARP Change Package, which had the following four themes of changes:

Theme 1: Building hope for clients' future and creating both staff & clients' expectations for recovery at initiation of care

Theme 2: Plan with clients meaningful goals that address their overall needs and are driven by individual clients' aspirations, strengths and barriers

Theme 3: Create a flexible array of recovery-oriented skills in provider team and design services, supports and interventions that support clients' goals and life purpose, reflect stages of recovery and wellness, as well as promote flow through the system.

Theme 4: Support meaningful roles, relationships and activities for clients in their communities

³ 5150: Section 5150 is a section of the California Welfare and Institutions Code (specifically, the [Lanterman–Petris–Short Act](#) or "LPS") which allows a qualified officer or clinician to [involuntarily confine](#) a person deemed to have a mental disorder that makes them a danger to him- or herself, and/or others and/or gravely disabled. A qualified officer, which includes any California [peace officer](#), as well as any specifically designated [county](#) clinician, can request the confinement after signing a written declaration. When used as a term, *5150* (pronounced "fifty-one-fifty") can informally refer to the person being confined or to the declaration itself, or colloquially as a verb}, as in 'Someone was 5150'd'.

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 ARP, 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 assess whether improvement is occurring. The learning collaborative measurement system creates a feedback system to inform teams of the results of their changes. The data provide teams with just enough information to guide their efforts. 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.

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 APR.

Teams used a tool for tracking the measures; they set up the necessary data collection and processes so they could review data frequently and over time. 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.

Agency Changes & Learning

From March through December 2012, agency teams selected ideas presented by faculty in learning sessions and/or described in the Change Package, and tested them to determine how to effectively adopt them in their respective environments. Below is a summary of the agencies' learning and results, organized around the themes and change concepts, identified by participants as being critical to achieving their improvement aims.

Theme 1: Building hope for clients' future and creating both staff & clients' expectations for recovery at initiation of care

Belief in and hope for recovery is a necessary foundation for an individuals' recovery. The learning amongst ARP 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. Leaders must emulate it, staff must embrace it and day-to-day processes must continually reinforce it. The following changes, presented by faculty and outlined in the change package, as well as developed by ARP teams, proved the most effective at building hope and expectancy of recovery.

Raise hope and expectations among staff: As with most changes, staff belief in recovery cannot be reliably trained. Its development correlates with that of skill development. Exposure to client success stories and 'academic knowledge' is only a starting point. Sustained, activated belief is achieved by staff experiences – both with their own clients and in partnership with other staff. This was demonstrated by a variety of teams. OCHCA tested increasing staff hope by exploring why they initially entered this work, which proved to be a very powerful experience for all the staff involved. MHA-LF developed agreements among staff that provide guidelines and create an obligation for staff to challenge each other when expressing pessimism or diminishing belief in the potential for clients to recover. This

Thematic Change Ideas

Theme 1

Building hope for clients' future and creating both staff & clients' expectations for recovery at initiation of care

Theme 2

Plan with client meaningful goals that address their overall needs and are driven by individual clients' aspirations, strengths and barriers

Theme 3

Create a flexible array of recovery-oriented skills in provider team and design services, supports and interventions that support clients' goals and life purpose, reflect stages of recovery and wellness, as well as promote flow through the system

Theme 4

Support meaningful roles, relationships and activities for clients in their communities

was reinforced with motivational interviewing strategies to help staff understand what stage of change they were in related to client's recovery and with a goal setting workshop regarding personal development for staff. San Diego also added a "recovery" topic to monthly all-staff meeting agendas to reinforce importance of focusing on client's recovery. OPK held small group meetings with staff to provide an environment for all clinical team members to review their beliefs/opinions about challenging clients, and obtain support from others.

Change questions that are asked of clients: Scripts and other talking guidelines may help staff become comfortable and eventually skillful in hope-oriented, strengths-based communication with clients. Use of these tools, though, must be reinforced through regular clinical supervision and coaching. Teams tested a wide array of means to alter interactions with clients to promote hope. MHA-LF tested using a 5 Possibilities document to engage consumers in conversations about thoughts, beliefs, and desires. OMI began using the "miracle question" with existing clients (for example, if you were to reach a point in your life where mental illness no longer interfered with your ability to do what you wanted in life, what would you be doing?). OCHCA, San Diego, Monterey, Didi Hirsch, and SF FSP focused on the quality of the client's life and what would make it better. San Diego developed a script to address Section 8 housing vouchers with clients, speaking specifically about recovery and hope.

Assess strengths: Using assessment of a client's strengths to build hope was successful when three key ingredients were in place:

1. Program management leads the way and maintains the focus and support;
2. Understanding of its value is achieved by staff who apply it to themselves; and,
3. The process of using it is tested and developed to learn how to make it routine and reliable.

Several teams tested methods to build hope by assessing clients' with the University of Kansas Strengths Assessment⁴. MHA-Lake Forest (MHA-LF) used the tool to raise client's expectations about recovery from the initial point of contact and raise hopes that recovery was possible. MHA-LF and Opportunity Knocks also used the Strengths Assessment with staff to help them become more acquainted with the tool, experience the process from the client's point of view, and identify their own strengths they bring to the table in their work with clients. Santa Clara's Narvaez program used the Strengths Assessment to better understand the hopes and dreams of clients, which also helped staff to become more hopeful about their clients' recovery. This in turn influenced intervention strategies and helped staff to focus on the clients' strengths.

Promote healthy choices: Promoting a consistent focus on healthy choices by staff and clients can create a shift in priorities; specifically the focus is increasingly is on positive change rather than problems as attention shifts to ways to support staff and clients in making health choices. The Healthy Choice Challenge was a change idea developed by the MHA-LF team to get staff and their clients to focus on just one healthy choice they could make each day to promote belief in recovery. This change idea led to an increase in the positive recovery oriented culture, which has since spread to others within and outside the MHA-LF program.

⁴ <http://mentalhealth.socwel.ku.edu/projects/Emerging/cm.shtml>

Use storytelling to promote belief in recovery: Storytelling can be an effective way to foster hope and belief in recovery, and has the greatest effect if there is structure and consistency in the storytelling to assure all clients have timely access to inspirational stories, multiple modalities are used (live, written, video, etc.), and stories are offered in different venues (client intakes, team meetings, peer activities, etc.). ARP teams tested and implemented a wide array of ways to use actual examples of clients' recovery to inspire both staff and clients. MHA-LF helped staff to suspend their disbelief that recovery might not be possible for a specific individual by sharing stories of when low expectations have been proven wrong. SF FSP, OMI and MHA-LA tested having peer staff share their recovery stories with new clients as part of Intake/Orientation to share the message that recovery is possible and should be expected. SF FSP also established a Recovery Committee to share individual recovery success stories (e.g. clients who have become employed, clients who have reconnected with family, clients who have met important life goals, etc.) at a weekly community meeting. San Diego started a monthly newsletter that includes a client success story that generated from the Strengths Assessment.

Use peers to demonstrate and promote hope and expectancy of recovery: Peers offer a unique contribution to raising awareness of recovery as a result of their individual progress through and experience with recovery. The storytelling approach described above is just one of multiple methods peers can use to promote hope. SF FSP, Didi Hirsch, MHA-LF and OMI tested and implemented supporting peers to meet with new clients in a variety of settings to both welcome them and to introduce key beliefs about recovery held by the program and how their own recovery would be supported.

Raise expectations and hope for recovery at Intake: Promoting hope and belief in recovery at intake when the hopeful message in a highly believable way; approaches that teams found effective included: by a client in recovery, talking clients' about hopes and dreams, recognizing progress already made, and providing hopeful options right away (e.g. social opportunities). OCHCA worked with clients to have them write their own stories of recovery, and then posted them on a bulletin board in the lobby and shared them with other clients during intake. OPK modified its orientation process (including use of a check list) for new members to include discussion of graduation and recovery expectations, and to build members' engagement as well as their knowledge and expectations of recovery. OMI tested having service providers state a wellness and recovery message prior to new intake to let clients know OMI is a clinic focused on wellness and recovery beliefs and what that means. Santa Clara had staff make phone calls to clients prior to their scheduled intake date to support them for taking the first step toward their recovery, introduce themselves, provide any information to clients about the services provided, and offer encouragement.

Many teams tested visual displays in reception and intake as a means of promoting hope. While these are relatively easy to develop, their effectiveness seems to be tied to the use of other, more active techniques of developing hope and belief. Visual displays can enhance and reinforce other changes, but in isolation have limited effect.

Use of mindfulness exercises to raise expectations and hope for recovery: While tools and techniques for mindfulness seem to be wide-ranging and variable in their effectiveness, the best are those that become imbedded in the way teams are managed. Mindfulness is essentially a management technique

for senior, middle and line managers to maintain a focus on recovery and high levels of hope. Kedren and MHA-LF tested using mindfulness exercises in staff meetings, which included identifying client successes over the previous week, how to stay constantly mindful of their practices and approaches and how these impact people's hope for recovery. This greatly helped staff to stay centered on how their thoughts and actions impacted others in their recovery.

Theme 2: Plan with clients meaningful goals that address their overall needs and are driven by individual clients' aspirations, strengths and barriers

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 then becomes actionable when providers help clients to use those strengths to progress toward achievement of their goals.

Use Strengths Assessment to identify and set meaningful and important goals – Using the Strengths Assessment, 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 toward goal achievement, and ultimately the amplification of a person's wellness. Multiple teams (MHA-LF, Kedren, Humboldt, Santa Clara, OCHCA, OMI, OPK, SF FSP, and Caminar) tested the Strengths Assessment to generate this kind of improvement. Monterey, OPK, Humboldt, OMI, MHA-LF, and Kedren found that using the Strengths Assessment improved the quality and usefulness of treatment plans, particularly in terms of making them more relevant and engaging for the clients for which they are created. The UK recommended methodology to use the Strengths Assessment proved most useful for teams – to carry out the assessment gradually, over several sessions and at the client's pace. Another key to its successful use was to view it not as a documentation requirement, but rather a clinical process that is supported by a written tool.

Put strengths in their most usable form to help clients achieve goals: Teams found that when they put strengths into their most usable form, staff 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. San Diego, MHA-LF and Caminar discovered that the Strengths Assessment process helped to identify a more comprehensive view of the person's current and desired quality of life. This included getting specific information on the Strengths Assessment that detailed what the clients was currently doing to stay well and specific strategies he/she had used in the past. As a result of this, clients were more hopeful that they could impact their own recovery. Staff were also able to link these strengths to clients' goals and then to craft highly individualized strategies to help them achieve these goals. Include consumer identified coping skills to build resilience in recovery and plan for day-to-day activities (MHA-LF)

Develop personal recovery plans: Several teams (MHA-LF, San Diego, Kedren, Humboldt, OPK) tested use of 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. OPK and Santa Clara discovered these impacts through their own testing of the Personal Recovery Plan process.

Mentor staff in the field: 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 field mentoring and also to build it into supervisor's schedule and responsibilities. MHA-LF, Caminar, and San Diego tested and to some degree implemented this approach to field mentoring.

Conduct strengths-based group supervision – 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). Monterey restructured team meetings to follow the six step process outlined in Strengths-based Group Supervision. Over time staff began to feel more comfortable with the process and reported that brainstorming strategies with their team was helpful in increasing the number of options for helping clients achieve goals and that using the Strengths Assessment in group supervision helped facilitate this. Other teams that tested the Strengths-based Group Supervision process were San Diego, MHA-LF, Kedren, OMI, Humboldt, OPK, SF FSP, and OCHCA. 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. Didi Hirsh tried revising Case Presentation format to utilize more Recovery-based language and promote more collaboration between participants.

Theme 3: Create a flexible array of recovery-oriented skills in provider team and design services, supports and interventions that support clients' goals and life purpose, reflect stages of recovery and wellness, as well as promote flow through the system

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. These must be tailored to each client's goals and life purpose; as such, systems need a wide array of services that can be used flexibly and responsively. While ARP did not, in fact, offer training or guidance on individual practices, it did support development of more generalized supports.

Use peers to support clients' 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. Several programs tested strategies around use of peers to support clients in making progress in their recovery. Peers were engaged to outreach to consumers for same-day access (MHA-LF), to co-facilitate transitions to lower levels of care (MHA-LF), to help clients complete Wellness Recovery Actions Plans (Kedren), run groups (Kedren, OPK), to do case management (Kedren), to do Strengths Assessments (Kedren, Monterey), to follow-up with clients after discharge from program (Humboldt, Monterey, SF-FSP), and to help clients identify activities and supports in the community (SF-FSP).

Make Access Easier: Same Day Access is an innovative quality-improvement initiative launched by the National Council for Community Behavioral Healthcare that has significantly increased savings, reduced staff time, cut wait times and strengthened client engagement at community behavioral health organizations (CBHOs) in several states. Several ARP teams tested strategies around same day access including: Humboldt, OMI, Didi Hirsch, and Monterey. Humboldt also created a new post-crisis outpatient group (Passport to Recovery group) that accelerates access to ongoing outpatient support. OCHCA tested an Open Access Model overcame logistical struggles to serve the clients that are coming in and re-engaging them in our services.

Use graduation checklists to help clients move through the system - Monterey tested use of a "graduation" checklist for clients who are in Level 5 to better assess readiness to transition to a lower level of care, which included identification of areas for follow up/support by client in the community and identify client's strengths (to identify areas not previously considered when discussing discharge). OPK modified its orientation process for new members to include discussion of graduation and recovery expectations at the beginning of enrollment. SF FSP, OMI and OPK used a Recovery Checklist to better assess clients readiness to transitioning from the program.

Other change ideas tested: Teams tested a variety of other change ideas they developed internally or identified independently to improve their ability to match services to need.

- Monterey worked to clarify for service providers the multi-level care system so they may provide a more appropriate match client's need with level of care. This process allowed identification of areas to strengthen, creating a picture for potential movement out of the system of care; and feeling more hopeful of the possibility for recovery. Monterey also tested a systematic use of WRAP (Wellness Recovery Action Plan) for clients previously identified in levels 4 or 5 in multi-level care system to help clients transition into the next level of care or out of the mental health system.
- OPK implemented a Seeking Safety group, an evidence based group for individuals battling with substance abuse and trauma. They also tested a change idea around sending an e-mail to the clinical team to inform staff members whenever a member is hospitalized or incarcerated to improve coordination of care for members. OPK tested starting a support group for Vietnamese members to address their needs, which was an idea that resulted from conversations with Vietnamese members about their experiences within the program. The objective is to strengthen the Vietnamese members' social support and provide them a safe environment to express their mental health concerns. OPK also started using doctor's and nurse practitioner's calendars to follow-up with members who miss their appointment. OPK created an Evaluation Task Force team with the intent of assuring that new members' basic needs are met and that they are linked or are in the linkage process to appropriate internal and external services by the end of the assessment period (first 60 days of enrollment).
- Humboldt tested doing follow-up calls within 3 days of discharge from the Psychiatric Emergency Unit (PES) to engage clients at their earliest stage of recovery and to return for MH Outpatient services.
- SF FSP tested asking CWF providers to report past experience with "stepping down" or graduating clients out of the FSP and what their experiences were, and what the outcomes were for the clients to help inform the transition mapping process SF FSP was developing.
- Didi Hirsh created an Engagement Specialist position to outreach clients who are marginally involved in treatment.
- OPK put in place a courtesy policy of responding to members' calls within 24 hours to foster improved communication with members and engagement with the program.
- MHA LF used new treatment plan documents to promote with new and existing consumers greater belief, hopes, desires.
- OMI began to identify and discuss clients who are ready to graduate from the clinic at a weekly meeting. Also tested having a Champions of Recovery group which designed to assist those clients identified in the weekly meeting.

Theme 4: Support meaningful roles, relationships and activities for clients in their communities

Throughout the efforts to build client hope and belief in recovery, discover and use clients' strengths, and provide beneficial services and supports, the simultaneous understanding and advancement of clients in their own communities is critical. All recovery services and supports should be undertaken in

the context of a client's community and pursued as a means to increase their integration into community and decrease their dependence on the public mental health services. Teams tested and implemented a variety of changes to assure hopes, strengths, plans and services are oriented to meaningful roles, relationships and activities in clients' communities.

MHA-LF tested having their Employment Specialist engage community partners and coached clients in meaningful community involvement. Kedren began having conversations in staff meetings about making partnerships in the community for employment and volunteering to help connect the clients and also tested working with clients to go into the community, including situations that have been triggers or provoked fear in the past as a means of helping clients work through their feelings in the moment and help them move on. SF FSP tested the formation of a "Graduation Cohort" to provide a group that will foster interest and confidence in access and utilizing community supports as a bridge to integration. Also, a peer specialist has been testing one-on-one meetings with clients to help them identify recovery goals (an activity in the community) and works with each client to pursue one or more activities identified.

System Supports

The four thematic sets of change ideas described above would have limited benefit without two categories of system supports: leadership involvement, and the collection and use of recovery-oriented data.

Involve leadership – 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 ARP 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 ARP 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.

Collect and use recovery-oriented data: Use of data to support client recovery (both individual and population) was not deeply developed nor was its value fully realized by ARP teams. Service providers, supervisors and managers need more support on generating and using data. However, all of the ARP teams collected at least some data on program outcomes throughout the learning collaborative. Kedren began tracking client outcomes in their OMA system and began to pull data out to look at positive outcomes such as employment, schooling, and independent living, as opposed to hospitalizations and

incarcerations. OPK started storing all of its members' information in one system which enabled them to regularly review members' outcomes with the clinical team as well as with the member-run advisory board. SF FSP used data captured in the DCR to generate monthly reports which were used to facilitate program improvements. Didi Hirsh and Santa Clara tested the ORS (measure of session efficacy) for each session with a clinician.

See Appendix G for a summary of teams' experiences with reporting core and supplemental measures, and Appendix H for actual reported results.

The Milestones of Recovery Scale⁵ (MORS) 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.

Most of the sites (MHA-LF, Kedren, Humboldt, OMI, Monterey, OPK, SF FSP, OCHCA, Santa Clara, and Didi Hirsh) used MORS to track the progress of recovery for the people served within their programs. Some of these sites were using MORS prior to ARP, but several tested this as a change idea once ARP began.

Some of the specific uses of MORS included:

- Sites reviewed MORS measures with staff in team meetings (OPK) 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.
- Client measurement of their own recovery using MORS (MHA-LF). This helped raise clients expectations about recovery by better understanding not only the concept but also recognize that attaining a higher level of recovery than currently experienced was possible.
- Identification of clients who are stuck at a particular level (OPK, Didi Hirsh, OCHCA). OPK specifically targeted clients who were stuck at a MORS score of 3 or 4. Didi Hirsh targeted clients who were stuck at a MORS score of 5.
- Identification of those individuals who went from being unengaged in services to engaged to develop learning on what helped these clients make this type of movement (OCHCA).

Other system support changes tested included:

- San Diego tested using Prochaska's Stages of Change to assess where a person is at in their recovery

⁵ Milestones of Recovery Scale: This is a tool to help individuals and their service providers measure where individuals are in their process of recovery – from when individuals need an intensive level of support to when individuals have achieved an advanced level of recovery and are no longer part of a system of care. Developed and supported by Mental Health America of Los Angeles.

- OPK celebrated recovery with all members at a recognition ceremony to instill hope and recognize milestones and incremental changes in members' different areas of life.
- Didi Hirsh began testing doing collaborative documentation with clients
- SF FSP established a Client Council to promote and practice a recovery philosophy and encourage client participation and input into many areas of the agency.
- OPK tested updating their information system, Caminar, to enable export and import of members' information to and from other agencies. This helped the program be aware of members' outcomes prior to enrollment, and foster a seamless mental healthcare system for transfers.
- SF FSP tested designing and generating reports to support the decision process regarding which clients would be most appropriate for the "graduation cohort", using Avatar services data, MORS, DCR residential and DCR Emergency Events history.
- OPK tested having their data analyst present members' outcomes to the staff on a monthly basis. Areas covered include members' rates of homelessness, incarceration, hospitalizations, and MIAs among members. The program also posted the outcomes on a data board, visible for members and staff to see. Data are also discussed at the program's member-run advisory board meetings. OPK also pre presented the results of Client Feedback Surveys which staff found informative.
- OPK tested administering the Addiction Severity Index to new members at enrollment and one year post enrollment to track the progress of members who have co-occurring disorders.
- San Diego revised their utilization management process to incorporate data to match services to client need. The review process included "categorical approval" for clients who: 1) are on conservatorship status; 2) who have a LOCUS⁶ score of 4,5, or 6; 3) who have been in the program for less than 1 year.
- San Diego tested tracking LOCUS and IMR⁷/RMQ⁸ reports through a database. Program Managers review monthly congregated information and individual scores for IMR/RMQ that have a one point difference. The Medical Records Clerk is assisting in tracking each client receiving scores every six months.
- OPK started tracking members' engagement in the community in four categories: health & wellness, religious or spiritual groups, community clubs, and individual interest groups.

⁶ LOCUS: The Level of Care Utilization System was developed by the American Association of Community Psychiatrists' Health Care Systems Committee Task Force on Level of Care Determinations. It was also developed in cooperation with St. Francis Medical Center of Pittsburgh and the suggestions of multiple reviewers across the country. http://www.communitypsychiatry.org/publications/clinical_and_administrative_tools_guidelines/locus.aspx

⁷ IMR: To measure clinician perception of client recovery the clinician version of the Illness Management and Recovery (IMR) scale will be used. The IMR has 15 items, each addressing a different aspect of illness management and recovery. Each item could function as a domain for improvement. Clinical staff members will be completing the IMR.

⁸ RMQ: To measure client perception of individual recovery the Recovery Markers Questionnaire (RMQ) will be used. The RMQ is a 24 item questionnaire developed by the Yale Program for Recovery and Community Health. All clients will be asked to complete the RMQ.

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 ARP project staff gathered knowledge about how to most 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. These are intended to enable over-arching improvements in the next collaborative, including to:

- Increase the involvement and support of agency leadership;
- 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;
- Increase the rapidity with which teams learn to effectively apply the Model for Improvement;
- Increase the number of high leverage changes teams are able to test and implement, and also prepare to spread;
- Improve the quality of the change package and the usefulness of the measurement system; and,
- Improve the experience of the collaborative for participants.

Recommendation #1 - Charter

As stated previously, project staff with the help of experts developed a pilot 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:

Through a collaborative learning process, behavioral health programs will make fundamental changes that promote recovery for individuals with serious mental illness, including those with co-occurring substance use and physical health disorders. These innovative changes will help people to develop meaningful, self-directed lives in their communities with a focus on improved:

- *Health,*
- *Housing,*
- *Purpose in daily life, and,*
- *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 along with a supporting diagram that provides participants big-picture context for individual changes. The changes should be structured around the following themes in the following order:

- Build hope and belief in recovery
- Get strengths in their most usable form to achieve goals
- Plan to achieve goals
- Work to achieve goals

Introduced throughout these themes would be changes to support processes to ensure clients' movement through services: including:

- Measurement of recovery progress and quality of helping relationship
- Strengths-based group supervision and field mentoring
- Performance feedback and skill development

See Appendix I for a diagram of these changes and their relationship to achieving the desired improvement.

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, as well as a wide array of 'advance measures' from which participants may select to support their individual charters;
- During Prework, give the participating teams a data collection form and electronic tool for collecting raw data and provide training ;
- Create a story or illustrative explanation for each measure to help participants understand their value;
- Develop several Clinical Information System⁹ options (e.g. PECSYS¹⁰ and a customized Access¹¹ tool) for participants;

⁹ Clinical Information System: To organize patient and population data to facilitate efficient and effective care

- Provide timely reminders for providers and patients
- Identify relevant subpopulations for proactive care
- Facilitate individual patient care planning
- Share information with patients and providers to coordinate care (2003 update)
- Monitor performance of practice team and care system

http://www.improvingchroniccare.org/index.php?p=Clinical_Information_Systems&s=25

- Start the improvement project related measurement during prework;
- Provide training in the use of clinical registries;
- Help organizations look at their data (not just ARP data) plotted over time; and,
- Integrate the improvement measures into the leadership discussions at the organization.

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

Recommendation #4 - Collaborative Activities & Processes

Study of the recently concluded ARP 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 effect 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: A lengthier pre-work period is recommended. ARP pre-work was approximately six weeks and it is recommended that this be extended to ten to twelve weeks. This extension would allow for the following additions and modifications to pre-work activities:

- Help key team members and leaders to prepare for their team's improvement work, including specific pre-work assignments and participation in special (virtual) sessions for the following individual participants:
 - Leaders (assignment: develop a big-picture plan for spread)
 - Team Leaders (assignment: conduct team development activity)
 - Data Lead (assignment: investigate current sources of data for measures; install and test CIS)
- During an early pre-work call, give all teams the assignment to test a process (relevant to ARP), and then during subsequent calls, follow-up on learning to promote the value of small-scale testing that is based on theory and predictions (PDSA language not yet introduced)
- Gather initial data for core and advanced measures

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:

¹⁰ PECSYS[®]: a Clinical Information System and Registry designed to help improve patient care. PECSYS[®] integrates evidence-based guidelines and known best practices into all of its tools and features reflecting the latest science in caring for a patient's condition(s). <http://www.pecsys.org/pecsys.shtml>

¹¹ Access: A tool to create desktop databases, including browser-based database applications. Data is automatically stored in a SQL database, so it is secure and scalable, and can be easily shared.

- Provide a better narrative reporting tool (to improve the quality of reporting of what was tested, what was learned and what action will follow) and support leaders to complete the tool in a useful way
- Support all faculty to clearly present change concepts and ideas, including at least one example PDSA for each idea presented
- Conduct in person planning sessions for each learning session at least two months prior to the session (LS #2 planning will begin before LS #1 takes place)
- Share learning session agendas and registration information at least six weeks in advance to allow teams to plan for full team participation (including senior leaders) and to gain travel approval
- Conduct regular (monthly) specialized calls for the following team members:
 - Senior leaders
 - Team leads
 - Data leads

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



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