(MTF draft 4.14.14)

Assuring safety, wellness and recovery in Hancock County – Building Recovery through Evaluation

Establishing an Evaluation Plan Year 01

Background

In May of 2013 the Community Advisory Board of the Hancock County Board of Alcohol, Drug Addiction and Mental Health Services established as its Vision and Preamble for Care certain Guiding Principles intended to be the foundation for future care provided in Hancock County. Those Principles sought the establishment of a Recovery Oriented System of Care (ROSC) guided by the Principles and definitions embedded in that community adopted Preamble.

After one year of community wide needs assessment and awareness trainings to strengthen this Vision both in clinical program development and by designing a tailored system transformation best capable of achieving ROSC in Hancock, an initial Implementation Plan was drafted for FY 2014 through 2017. This work and that plan must now be evaluated to ensure accountability and measurement of ongoing progress.

The evaluation plan though must take into account several related concerns. For example, Hancock must meet other requirements of Ohio as stipulated by the State within its annual funding. Additionally current needs and services must not be abruptly halted nor be exempted from their own accountability criteria, even if not in this Plan. All publically funded services should be held publically accountable for impact, quality and efficiency. Additionally, different segments of service provision, e.g. prevention and intervention need to be coordinated within the Implementation Plan and evaluation for common focus, true impact and relevance to ROSC to the community. Finally, in developing this evaluation plan for ROSC several other key documents are to be recognized as guiding references. Included here would be the National Behavioral Health Quality Framework (2013 draft), Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices (White, 2008), Strategic Prevention Framework-State Improvement Grant (SPF-SIG/SAMHSA/CSAP/2013), Data-Based Planning for Effective Prevention: State Epidemiological Outcomes Workgroups (SAMHSA, 2014) and Philadelphia Behavioral Health Services TRANSFORMATION Practice Guidelines for Recovery and Resilience Oriented Treatment (New England ATTC, 2012) - all relevant guides for establishing the present initial evaluation plan.

Responsibility, Leadership and Relationship:

The responsibility for the evaluation of success within a ROSC lies ultimately in a partnership between those empowered and entrusted to deliver service to the community and the community itself. In short best science and practice is to be brought to joint oversight with the community through evaluation and further implementation, change or alteration of course. It should also be noted that within ROSC there are at least two forms of evaluation: (1) **process** evaluation and (2) **outcomes**. Progress is measured in both.

Hancock County:

In Hancock County the ADAMHS Board has established a ROSC Leadership Team that should hold responsibility, with the ADAMHS Board for the development of the ROSC Implementation Plan and the initial measurements and outcomes sought therein. The ADAMHS Board should establish the coordination of community needs with other expectations (e.g. state) while working with ROSC Leadership to design an Implementation Plan (2014-2017) - and the evaluation and outcomes therein to meet the goals of both. Both the Board and ROSC Leadership should have close ties and strong provider and community representation, especially including those in recovery or their families, racial and ethnic minorities and voices of high-need populations not generally heard, e.g. veterans, LGBT, youth, criminal justice, elderly, pregnant women, poverty, etc. ROSC relatedness and roles should be considered in all of the populations served and at all levels of the continuum of care: prevention, intervention, treatment and recovery.

The ROSC Implementation Plan further establishes targeted Sub-Committees for important issues. Included here are committees on Residential Care and Housing, Medical ROSC with Opioid ROSC, Judicial ROSC, Peer –Provider Relations and training, ROSC workforce (w/ U. of Findlay), etc. as well as ongoing community prevention and education. Each sub- committee should have a specific focus and its own identified leadership and defined connection to the ROSC Leadership Group .The goals of each sub-committee should be coordinated and communicated into the ROSC Implementation Plan. A Sub-Committee might take on a charge from ROSC leadership or design their own grass root up focus, needs and goals that are then reported to the ROSC Leadership Committee and the ADAMHS Board. As time proceeds other Sub-Committees or Task Groups may form as needed to meet the implementation goals and to further ROSC development in the community. Appendix A depicts a community ROSC organization and relationship chart.

Establishing Initial Evaluation Method and Measures:

After reviewing the above referenced documents and Hancock ROSC Framework Implementation Plan many initial desired outcomes might be sought. In building ROSC it is critical to not move too quickly or too far for the existing providers and community to adjust and change. In short, just a few well thought initial evaluative indicators each year will allow system transformation should be the goal as opposed to promulgating many specific provider targets which may not need to be stated or might be more easily achieved in contracts or performance measurement. Evaluation of ROSC should focus more on community wide reported outcomes of improved health, wellness and recovery of the individual, family and community.

The Hancock ROSC Framework Implementation Plan establishes five broad areas for Implementation that will need evaluation:

1. Aligning Treatment with a Recovery-Oriented Approach
2. Integrating Peer and Other Recovery Supports – Mobilizing and Activating the Recovery Community
3. Measuring Performance Improvement and Evaluation
4. Promotion of Population and Community Health with a Focus on Prevention and Early Identification and Intervention
5. Monitoring Fiscal, Policy and Regulatory Alignment and Evaluation of it.

It is the role of the ADAMHS Board and ROSC Leadership Group to establish initial measures for these five areas on implementation. ADAMHS staff should suggest initial measures for approval.

Additionally there are various “methods” of evaluation that the ADAMHS and ROSC Leadership group need to consider before designing the Year 01 Evaluation.

Methods to Consider:

Method 1. In year 01 many communities have established measures that demonstrate improved "access" (both to early screening (SBIRT) and to total number served with SUD and to timeliness of admission (within 24hrs (if urgent) or 1 week (if not urgent)), "retention" (if screened as not problematic use but not SUD referred to OP treatment in community or home; if diagnosed SUD receives at least 90 day continuum of care; and "outcome" (status of recovery at 90 days, 6 months and (if possible) 1 year). These three measures combined with (a few) selected recovery measures (see Method 3/White below) have shown to tie together many of the ROSC system and person goals in year 1 while not necessarily over-burdening the system of care and providers.

Method 2. Another method to establish initial measures is to study the National Behavioral Health Quality Framework (SAMHSA, Draft 8.22.13) and its currently recommended and future measures as they can be related to Hancock's ROSC Implementation Plan. While these NBHQ measures are broader in focus and more inclusive of MH and Integrated Care than the ROSC Implementation Plan, they are all mutually relevant and synergistic in aim. To this end a suggested model might be to compare the ROSC Implementation Plan with the NBHQ measures for Payer/System/Plan, Provider/Practitioners and Patient Populations, pages 8-22 of NBHQ Framework, for the measures that can connected to the ROSC Implementation Plan. In doing so local projects become aligned to Federal funding from the start but as local first. Local needs and solutions and measures should always be first.

For example:

Hancock ROSC Implementation Plan seeks:

To Align Treatment with a Recovery-Oriented Approach

Year 01 Implement Recovery Oriented Clinical Assessment that includes SBIRT and linkage to Peer Supports throughout.

The above Year 01 Goal aligns with NBHQF Goal 1 for EFFECTIVE prevention, treatment and recovery practices that can be measured by number of SBIRT screens, retention in care, changes in employment (increased/no change) or school status (expulsions/suspensions); feedback from families about care provided; family involvement in MH/SU treatment; % of patients with annual encounter data with a primary care; follow-up data from Emergency Room and follow-up care, etc.

By finding this connectedness both goals and the measures for evaluation are reinforced.

Method 3. Another method that may be more direct is to simply establish or contract for specific ROSC measures of the current System (self report) , Practitioners and Individuals in care (see White, 2008, p.26). For example:

ROSC System Measures:

A. Recovery representation/orientation
B. Organizational health and stability
C. Health and stability of administrative/clinical leadership
D. Cultural/political status
E. Capitalization, funding diversification (for ROSC)
F. Financial Stewardship of agencies
G. Institutional relationships (for transformation to ROSC)
H. Workforce and workplace composition and stability
I. Technological capabilities
J. Adaptive capacity for change

ROSC Process Measures:

A. Treatment attraction and access
B. Screening, assessment and level of care placement
C. Composition of service team
D. Service relationship (engagement, retention and discharge status)
E. Service dose, scope and quality
F. Locus of service delivery/influence if post-treatment recovery environment
G. Assertive linkage to communities of recovery
H. Post-treatment monitoring, support and early re-intervention

ROSC Recovery Outcome Measures

A. Pre & Post-treatment changes in:
   - AOD use/consequences
   - Living environment
   - Physical health and health care costs
   - Emotional health
   - Family relationships and family health
   - Citizenship (legal status, education, employment, community participation, community service)
   - Quality of life (spirituality, life meaning, and purpose)

B. Post-treatment Service/Support Utilization Patterns
   - Utilization of professional services
   - Utilization of indigenous recovery supports and institutions.
C. Changes in Family and Community Recovery Capital

Method 3 is simply applying the measures to its appropriate level of service: System, Process, Outcome and reporting on attainment. This method gives clear accountability and easily recognizable progress in both process and outcomes.

Method 4. This method would be design a measure for each item on the Hancock ROSC Implementation Plan that also ties to NBHQ and the ROSC Recovery (White) measures. This would be perhaps the most relevant method for evaluation but would require more thought and detail in application. The ADAHMS Board and ROSC Leadership Group concur on the implementation plan and then, in the light of NBHQ and Recovery Measures, design synergistic measures related to implementation. Such a plan might involve an independent evaluator to design, evaluate and write up the Evaluation. Such evaluation, while somewhat independent, need not be uninstructive as it can be collaborative with those being evaluated all along the way and documented as a "collaborative evaluation" of process and outcomes as impacted by the process itself.

Ultimately evaluation sets a course. The ROSC Implementation Plan begins to shape FY'16 and FY'17 but will be refined based on FY'14 and FY'15. As payment methodologies change performance and accountability will be become even more crucial for the values of each community and best practice of science and medicine to be assured of stature and progress. Additionally giving desired destinations to all involved allows them to define how to get there as opposed to telling them how to which is often much less productive. In establishing this first ROSC evaluation plan it will be more important to obtain shared Vision and Principles and effort and to achieve common goals than spelling out how to achieve them and not assisting those who may need help in doing so.

Appendix B initiates a Method 4 "straw-man" evaluation for Board discussion based on Year 01 ROSC Implementation Plan and the defined roles, responsibilities, relationships and methods. If taken to its full analysis it will become much more detailed (e.g. practice guidelines (e.g. Philadelphia Model) and less generic. The ROSC Implementation Plan is by its nature self-evaluative over time. Improving access, retention, outcome and status – all connected to peer supports - over time with specifically related measures of recovery may be all we need to start (see Appendix C). Deciding on a method of evaluation is the first decision; then setting up the measures most important.

APPENDIX A

Visualization of Evaluation

Federal/State Requirements

ADAMHS BOARD

(Final local authority)

ROSC Leadership Committee

(Establishes Overall ROSC Transformation Implementation Plan and Accountability)

Sub-Committees on Key Areas

(Each accepts assigned task from ROSC Leadership and defines measures of evaluation for task – may be a report, specific data, other measures as recommended by the Sub-Committee)

The process of information flow and accountability is as needed to accomplish a task. For example, a sub-committee may request the help of ROSC Leadership on a project. Outcomes of projects are reported to Sub-Committee Chairs who report to ROSC Leadership who reports to ADAMHS. All involved: ADAMHS, ROSC Leadership, ROSC Sub-Committees shall have joint provider and community representation with those in recovery or their families and the community at-large included.

APPENDIX B

Draft ROSC Evaluation Plan Year 01

This strategy includes ALL of the ROSC thinking within the above methods noted to be synergistic and in coordination with the ROSC Implementation Plan and Preamble for Care.

FY'14 Implementation Plan
Target Area:
Aligning Treatment with Recovery-Oriented Approach
(Each Target for Implementation should have a measurement defined by ROSC Leadership)

1. Recovery Oriented Clinical Assessment that includes SBIRT and linkage to peer supports throughout.

   System: Conduct training in SBIRT and use of Peer Supports and design model that includes both at all levels of care by FY'15. Responsibility: ADAMHS and ROSC Leadership

   Process: Train all providers and community in ROSC, SBIRT and Peer roles and design coordinated plan for implementation of services by location by July 1, 2014. Responsibility: ADAMHS/Century/Peers/SBIRT trainer.

   Outcome/Population: Earlier screening, intervention and referral to treatment; fewer hospital emergencies; expanded treatment utilization, fewer OD and OD deaths, linkage to PS for all clients and families. Responsibility: ADAMHS/ROSC/Century/Peers/ER/Coroner

2. Outreach/Engagement and Recovery Check-ups

   System: Review science and best practice for outreach/engagement, recovery check-ups; Provide education and training on types and effectiveness of check-ups. Responsibility: ADAMHA/ROSC/Century/trainer

   Process: Outreach to MDs and PCPs and all providers about value of continuing care and ways to provide it, early re-intervention, etc. and report. Responsibility: ROSC Leadership/Peers

Outcomes/Population: improved length of stay/compliance in treatment (dose of care); earlier re-intervention in reoccurrence; reduced OD and death. Responsibility: providers, peers.

3. Residential Treatment

   System: Evaluate the need for residential detox and rehab (ASAM level II) in Hancock. Responsibility: ADAMHS/ROSC/hospital and medical staff/Century.

   Process: Based on evaluation and need and in close coordination with hospital based care locate a site and conduct feasibility for residential care; develop a business plan; develop patient plan along ASAM; coordinate with higher (level IV hospital) and lower (Level II IOP/Partial) levels of care in community. Responsibility: ADAMHS/ROSC/hospital/Century/peers

   Outcomes: Complete continuum of care for citizens by having residential detox and rehab in Hancock County; reduce OD, deaths, incarcerations. Responsibility: ADAMHS/ROSC/Century/hospital/court/peers

4. Medication Assisted Treatment (opioid treatment).

   System: Study and expand best and proven practice that uses medication supported care in a manner consistent with recovery management, ROSC and the values of the community. Responsibility: ADAMHS/ROSC/Justice/Century/peers/ hospital and opioid treatment providers

   Process: Establish a special ROSC MAT Sub-committee of those with role to define a community-best practice shared philosophy and guidance that can prevent use and problems, educate the community as to dangers of opioids and available treatment alternatives; expand access to MAT; reduce diversion of medications used in MAT and involve interdiction as appropriate. Responsibility: same as those in System.

   Outcomes: Less demand for opioid treatment; wider acceptance and use of MAT and recovery measures established therein; fewer OD and deaths related to opioids; provider monitoring with Interdiction as warranted. Responsibility: ADAMHS/ROSC/Justice/Century/peers/hospital/ opioid treatment provider data on improved education, access and availability of care matched to need and varied treatment approaches; connectivity and continuity of care across systems (CJ-Treatment); reduced ER/OD/death, peer supports in evidence throughout, etc.

Appendix C

Consultant SAMPLE Year (01) ROSC Evaluation

2013 2014

1. Increased access to care:
    - Community ROSC Education Provided
    -SBIRT use
    -total citizens served
    -# Linked to Recovery Supports
    -Pre and/or post incarceration linkage to treatment:
        - linkage to RS
    -Jail diversion treatment
    -timeliness of treatment:
        - less than one day
        - less than one week
        - greater than one week
2. Retention in care:
    -screened and discharged
    -screened and referred to treatment
    -in treatment with Recovery Support
    -of total served #completed 90 day continuum of care
    -of total served with RS # completed 90 day continuum of care
3. Outcomes:
    - OD
    - OD deaths
    - Suicides
    - Suicide while in treatment
    - ER visits
    - Re-incarceration within 90 days of prior release from jail
    - Re-entry to more acute treatment within 6 mos. of initial treatment
    - AOD use at 90 days
    - Abstinent at 90 days
    - Job
    - Housing
    - Family status improved