Recovery Management Practices

Authority: Managing Entity Contract A-1.1.2 and C-1.2.3; F.S. 394.453(1)(c), 394.4573, 394.9082; Department of Children and Families Guidance Document 35

Requirement: Contract

Frequency: Ongoing

Description:

The State of Florida is committed to a more effective delivery of services that reflect recovery management concepts and practices. These practices are accomplished using Florida's Recovery-Oriented System of Care (ROSC) Framework. This document provides best practice standards to transform delivery of care to one that focuses on sustainable wellness and recovery.

Definitions:

A. **Recovery –** As defined in s. 397.311(37), F.S.

Through key stakeholder engagement, SAMHSA developed the following working definition of recovery:

Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

This definition describes recovery as a process, not an end state. Complete symptom remission is neither a prerequisite of recovery nor a necessary process outcome. Recovery can have many pathways including professional clinical treatment and use of medications; family, school, and faith-based supports; peer support and other approaches. Four major dimensions support a life in recovery:

1. Health: Learning to overcome, manage, or more successfully live with symptoms; and making health choices that support one's physical and emotional well-being.
2. Home: A safe, stable place to live.
3. Purpose: Meaningful daily activities such as, work, school, volunteer activities, or creative endeavors; an increased ability to lead a self-directed life; and meaningful engagement in society.
4. Community: Relationships and social networks providing support, friendship, love, and hope.

B. **Recovery Management (RM):** A philosophical framework for organizing treatment services to provide pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality-of-life enhancement for individuals and families affected by behavioral health disorders.

C. **Recovery-Oriented:** Recovery-Oriented care recognizes that each person must be the agent of and the central participant in their own recovery journey. All services and supports need to be organized to support the developmental stages of this process.
Services should instill hope, be person and family-centered, offer choice, elicit and honor each person's potential for growth, build on a person's and family's strengths and interests, and attend to the overall quality of life, including health and wellness. These values can be the foundation for all services regardless of the service type.

D. **Recovery-Oriented System of Care (ROSC):** A value-driven framework to guide transformation of a behavioral health system of care. The framework structures behavioral health systems to involve a network of clinical, nonclinical services, and supports that sustain long-term, community-based recovery. Formal and informal service networks are developed and mobilized to sustain long-term recovery for individuals and families impacted by behavioral health disorders. ROSC reflects variations in each community's vision, institutions, resources, and priorities. The "system" is not a treatment agency but a macro-level organization of a community, a state, or a nation.
E. **Recovery Capital:** Recovery capital is the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery.
F. **Recovery Support:** As defined in s 397.311(40), F.S.
G. **Support Services:** As defined in s. 394.67(16)(c), F.S. Peer support is giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation through the shared experience of emotional and psychological pain.
H. **Peer specialist** – An individual who:
    1. Self-identifies as a person who has direct personal experience living in recovery from mental health and/or substance use conditions.
    2. Has a desire to use their experiences to help others with their recovery.
    3. Is willing to publicly identify as a person living in recovery for the purpose of educating, role modeling and providing hope to others about the reality of recovery, and
    4. Has had the proper training, including a review of ethics and boundaries, and the experience to work in a provider role.
I. **A family peer specialist** self-identifies as a person who has direct, personal experience as a family member or caregiver of a person living with mental health and/or substance use condition. Military veteran and youth-certified specialists also attest to lived experience commensurate with the credential track they are seeking. LSF Health Systems refers providers to the guidelines established by the Florida Certification Board for the CRPS credentials.

ROSC Transformation Overview

Based on the Department's Florida Substance Abuse and Mental Health Plan Triennial State and Regional Master Plan, Florida's behavioral health, recovery-oriented transformation includes:

I. Priority Areas to Foster:
1. **Collaborative Service Relationship** indicated by a mutual service relationship between the provider and the service recipient that shift from a hierarchy model to the shared decision-making process and best practices that support the service recipients.
2. **Cross-System Partnerships** indicated by strategically leveraging resources and working across sectors to achieve common goals.
3. **Community Integration** indicated by assertively connecting service recipients to natural community-based resources to promote development of interest, skills, and supportive relationships.
4. **Community Health and Wellness** indicated by a focus on prevention, early intervention, wellness and increased recovery capital through targeted community education, strategic partnership development, and improved connections between system and local communities.

5. **Peer-based Recovery Support** indicated by increasing access to peer-based recovery support services.

II. Goals of a Recovery-Oriented System of Care

1. Promote good quality of life, community health and wellness for all.
2. Prevent the development of behavioral health conditions.
3. Intervene earlier in the progression of illnesses.
4. Reduce the harm caused by substance use disorders and mental health conditions on individuals, families, and communities.
5. Provide the resources to assist people with behavioral health conditions to achieve and sustain their wellness and build meaningful lives for themselves in their communities.

While LSF Health Systems intends to transform its Network Service Providers to a more recovery-oriented system, the Department of Children and Families acknowledges regional and community variety in terms of visions, institutions, resources, and priorities. Because of these variations, transformation practices discussed below are not proscriptive and the Department does not expect that all practices will be executed in every region or community.

Table 1 includes a list of best practice standards and changes in practice to review in Quality Improvement efforts and policy and procedures. The Department and Managing Entity will provide ongoing technical assistance for implementation in addition to engaging the network service provider in RM monitoring events.

<table>
<tr><th colspan="3">Table 1 ROSC Implementation Crosswalk</th></tr>
<tr><th>Best Practice Standards</th><th>Performance Arenas for Quality Improvement Monitoring</th><th>Potential Practice Changes</th></tr>
<tr><td>Assessment: Greater use of global and strength-based assessment instruments and interview protocol; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stages of recovery.</td><td>Meeting Basic Needs</td><td>Conduct Global Assessments: Use holistic, culturally relevant assessments, use strengths-based assessment procedures and interview protocols; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stage of recovery. Focus the assessment on multiple life domains rather than primarily on the presenting problems.</td></tr>
<tr><td rowspan="6">Clinical Care: Greater accountability for delivery of services that are evidence-based, gender-sensitive, culturally competent, and trauma informed; greater integration of professional counseling and peer-based recovery support services; considerable emphasis on understanding and modifying each client's recovery environment; use of formal recovery circles (recovery support network development).

Service Dose and Duration: Dose and duration of total services will increase while number and duration of acute care episodes will decline; emphasis shifts from crisis stabilization to ongoing recovery coaching; great value placed in continuity of contact in a primary recovery support relationship over time.

Post-treatment Checkups and Support: Emphasis on recovery resource development (e.g., supporting alumni groups and expansion/diversification of local recovery support groups); assertive linkage to communities of recovery; face-to-face, telephone-based, or Internet-based post-treatment monitoring and support; stage-appropriate recovery education; and, when needed, early re-intervention.</td><td rowspan="6">Comprehensive Services</td><td>Promote Retention: Enhance rates of service retention and reduce rates of service disengagement and administrative discharge by utilizing outreach workers, enhancing peer-based recovery support services in the treatment context, providing culturally competent services, providing a menu of service options so that care is individualized, and incorporating family members and other important allies as desired. Develop assertive approaches to helping people remain connected to natural community-based supports.</td></tr>
<tr><td>Expand the Focus of Services and Supports: Expand the focus beyond sobriety, symptom management, or biopsychosocial stabilization, to assisting individuals with building lives in the community and promoting community health. Focus on what people and communities want to become rather than what we want them to stop doing. Strengthen the family and community contexts so that individuals have increased access to natural supports, which sustain recovery and wellness beyond their involvement in a treatment episode. Facilitate the development of recovery maintenance skills rather than only recovery initiation skills. Provide clinical services that are recovery-focused, evidence-based, developmentally appropriate, gender-sensitive, culturally competent, trauma-informed and integrated with a broad spectrum of non-clinical recovery support services. Provide prevention supports that strengthen individual, family and community protective factors and reduce risk factors for substance use.</td></tr>
<tr><td>Ensure a Sufficient Continuum of Care with Appropriate Dose/Duration of Services: Provide doses of treatment services across levels of care that are associated with positive recovery outcomes. Facilitate continuity of contact in a primary recovery-support relationship over time and across levels of care.</td></tr>
<tr><td>Develop strong cross-system partnerships to achieve common goals: Build meaningful collaborations across systems such as criminal justice, behavioral health, child welfare, housing, public health, education, transportation, to strategically leverage resources and achieve intersecting goals.</td></tr>
<tr><td>Increase Service Access: Assure rapid access to treatment with minimal wait times. During unavoidable wait times, engage people through peer-based supports within treatment. Ensure that there are no limitations to accessing treatment based on past utilization and/or outcomes.</td></tr>
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Table 1 ROSC Implementation Crosswalk

Best Practice Standards	Performance Arenas for Quality Improvement Monitoring	Potential Practice Changes
Clinical Care: Greater accountability for delivery of services that are evidence-based, gender-sensitive, culturally competent, and trauma informed; greater integration of professional counseling and peer-based recovery support services; considerable emphasis on understanding and modifying each client's recovery environment; use of formal recovery circles (recovery support network development).	**MAT**	***Conduct Global Assessments:*** Use holistic, culturally relevant assessments, use strengths-based assessment procedures and interview protocols; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stage of recovery. Focus the assessment on multiple life domains rather than primarily on the presenting problems.
		Promote Health Activation: Shift towards philosophy of choice rather than prescription of pathways and styles of recovery/support, greater client authority and decision making within the service relationship, emphasis on empowering clients to self-manage their own recoveries and identify their personal life and treatment goals. Similarly, empower the community to identify their strengths that can be mobilized to promote wellness.
Assessment: Greater use of global and strength-based assessment instruments and interview protocol; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stages of recovery.	**Strengths Based Approach**	***Facilitate Individualized, Person Centered Service Planning:*** Ensure that treatment and recovery/wellness planning processes are individualized, directed by the person/family, and are grounded in the broader life goals that people have for themselves rather than clinical goals.
Service Relationship: Service relationships are less hierarchical with counselor serving more as ongoing recovery consultant than professional expert; more a stance of "How can I help you?" than "This is what you must do."		***Promote Health Activation:*** Shift towards philosophy of choice rather than prescription of pathways and styles of recovery/support, greater client authority and decision making within the service relationship, emphasis on empowering clients to self-manage their own recoveries and identify their personal life and treatment goals. Similarly, empower the community to identify their strengths that can be mobilized to promote wellness.
Role of Client: Shift toward philosophy of choice rather than prescription of pathways and styles of recovery; greater client authority and decision-making within the service relationship; emphasis on empowering clients to self-manage their own recoveries.	**Customization and Choice**	***Promote Health Activation:*** Shift towards philosophy of choice rather than prescription of pathways and styles of recovery/support, greater client authority and decision making within the service relationship, emphasis on empowering clients to self-manage their own recoveries and identify their personal life and treatment goals. Similarly, empower the community to identify their strengths that can be mobilized to promote wellness.
		Promote Collaborative Service Relationships: Shift the relationship with clients and community members from a hierarchical expert-patient model to a partnership/consultant model. The helping stance changes from "this is what you must do" to "how can I help you?"

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Service Relationship: Service relationships are less hierarchical with counselor serving more as ongoing recovery consultant than professional expert; more a stance of "How can I help you?" than "This is what you must do."		***Expand the Focus of Services and Supports:*** Expand the focus beyond sobriety, symptom management, or biopsychosocial stabilization, to assisting individuals with building lives in the community and promoting community health. Focus on what people and communities want to become rather than what we want them to stop doing. Strengthen the family and community contexts so that individuals have increased access to natural supports, which sustain recovery and wellness beyond their involvement in a treatment episode. Facilitate the development of recovery maintenance skills rather than only recovery initiation skills. Provide clinical services that are recovery-focused, evidence-based, developmentally appropriate, gender-sensitive, culturally competent, trauma-informed and integrated with a broad spectrum of non-clinical recovery support services. Provide prevention supports that strengthen individual, family and community protective factors and reduce risk factors for substance use.

Table 1 ROSC Implementation Crosswalk

Best Practice Standards	Performance Arenas for Quality Improvement Monitoring	Potential Practice Changes
Engagement Greater focus on early identification via outreach and community education; emphasis on removing personal and environmental obstacles to recovery; shift in responsibility for motivation to change from the client to service provider; loosening of admission criteria; renewed focus on the quality of the service relationship. **Retention:** Increased focus on service retention and decreasing premature service disengagement; use of peers, outreach workers, recovery coaches, and advocates to reduce rates of client disengagement and administrative discharge. **Attitude toward Re-admission:** Returning clients are welcomed (not shamed); emphasis on transmitting principles and strategies of chronic disease management; focus on enhancement of recovery maintenance skills rather than recycling through standard programs focused on recovery initiation; emphasis on enhancing peer-based recovery supports and minimizing need for high-intensity professional services.	**Opportunity to Engage in Self-Determination**	***Facilitate Individualized, Person Centered Service Planning:*** *Ensure that treatment and recovery/wellness planning processes are individualized, directed by the person/family, and are grounded in the broader life goals that people have for themselves rather than clinical goals.* ***Peer-based Recovery Support Services:*** Expand the availability of non-clinical, formal (paid) and informal (non-paid) peer-based recovery support services and integrate them with professional and peer-based services.
Service Delivery Sites: Emphasis on transfer of learning from institutional to natural environments; greater emphasis on home-based and neighborhood-based service delivery; greater use of community organization skills to build or help revitalize indigenous recovery supports where they are absent or weak. **Service Relationship:** Service relationships are less hierarchical with counselor serving more as ongoing recovery consultant than	**Network Supports and Community Integration**	***Promote Community Integration:*** Facilitate community integration by supporting people in identifying their personal dreams, goals, and preferences for their life. Connect them to relevant resources and walk alongside them to develop the interest, skills and relationships that will enable them to enhance their life. Collaborate with indigenous recovery-support organizations (e.g., faith community); assertively link people to local communities of recovery; participate in local recovery education/celebration events in the larger community and advocate on issues that affect long-term recovery in the community (e.g., issues of stigma and discrimination). Mobilize and increase collaboration amongst diverse community resources. Partner with the community in a manner that values and integrates the knowledge, expertise, and strengths of community members. ***Promote Collaborative Service Relationships:*** Shift the relationship with clients and community members from a hierarchical expert-patient model to a partnership/consultant model. The helping stance changes from "this is what you must do" to "how can I help you?"

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Best Practice Standards	**Performance Arenas for Quality Improvement Monitoring**	**Potential Practice Changes**
professional expert; more a stance of "How can I help you?" than "This is what you must do."		***Conduct Strength-Based Community Asset Mapping:*** Support prevention efforts that use a strategic approach to assess the strengths and assets within communities, rather than focus primarily on needs assessments, gaps, and identified problems.
Attitude toward Re-admission: Returning clients are welcomed (not shamed); emphasis on transmitting principles and strategies of chronic disease management; focus on enhancement of recovery maintenance skills rather than recycling through standard programs focused on recovery initiation; emphasis on enhancing peer-based recovery supports and minimizing need for high-intensity professional services.		***Assertively Engage All Community Members:*** Promote prevention, early engagement, and intervention via outreach and community education. For those in need of intervention, emphasize removing personal and environmental obstacles to recovery through meeting basic needs; ensure that the responsibility for motivation to change shifts from clients to service providers; use inclusive admission criteria rather than emphasis on exclusionary criteria.
		Broaden Service Delivery Sites: Increase the delivery of community integrated neighborhood and home-based services and expand recovery support services in high-need areas. Utilize and link people to existing community-based resources rather than duplicating efforts and recreating resources within segregated, institutional environments. Assist people in developing a network of natural recovery supports in order to increase their recovery capital.

The Network Service Provider and any applicable subcontractor shall:

- Begin to incorporate specific Best Practice Standards and Practice Changes in Table 1 into policy and procedures, service protocols and monitor agency progress and compliance with the Performance Arenas for Quality Improvement.
- Incorporate concepts designed to bolster the role of peer support and ROSC concepts by incorporating the elements of the Florida Peer Services Handbook 2016, available at: https://www.myflfamilies.com/service-programs/samh/publications/ including structured peer supervision on an individual and group basis.
- Support programmatic changes to include prevention and early intervention.
- Promote adoption of sustainable recovery-oriented practices.
- Use, at minimum, the following tools to assess recovery-oriented activities:
    - Annually apply the Provider Self-Assessment/Planning Tool process for Implementing Recovery-Oriented Services (SAPT) and focus on improvements among three primary domains, Administration, Treatment, and Community Integration. The tool is available at: https://www.usf.edu/cbcs/mhlp/tac/documents/toolkits/self-assessment-tool-recovery-oriented-mental-health.pdf,
    - The Recovery Self-Assessment-R (RSA) is available at: https://medicine.yale.edu/psychiatry/prch/tools/rec_selfassessment, and
- Require peer specialists who work in recovery-support service roles to:
    - Use the Recovery Capital Scale tool as a foundation to inform the recovery planning process (available at Recovery Oriented System of Care | Florida Department of Children and Families Recovery Oriented Quality Improvement Specialist and through the Managing Entity ROSC lead).
    - Receive standardized peer supervision from peer supervisors trained in same.
- Provide standardized training on Recovery Management best practices in New Employee Orientation and refresher training.

The Managing Entity shall:

- Incorporate specific Best Practice Standards and Potential Practice Changes in Table 1 into Network Service Provider subcontracts and monitor compliance with the Performance Arenas for Quality Improvement Monitoring aligned with the specific standards and changes selected.
- Incorporate concepts designed to bolster the role of peer support and ROSC concepts with community stakeholders incorporating the elements of the Florida Peer Services Handbook 2016, available at: https://www.myflfamilies.com/service-programs/samh/publications/
- Support programmatic changes to include prevention and early intervention.
- Promote adoption of sustainable recovery-oriented practices.
- Analyze and align current administrative, fiscal, policy, monitoring, and evaluation functions with recovery-oriented concepts using the Best Practices Standards in **Table 1**.
- Identify opportunities to promote the expansion of peer-based recovery support services and recovery communities, enhance the role of peers in the workforce, and support development of peer-run organizations in the network.
- Monitor Network Service Providers' utilization of the Self-Assessment/Planning Tool (SAPT) and document areas of improvements from the SAPT and the Recovery-Oriented Quality Improvement process available at: Recovery Oriented System of Care | Florida Department of Children and Families (myflfamilies.com)
- Include the Department's local Recovery-Oriented Quality Improvement Specialist (ROQIS) in Managing Entity Quality Improvement monitoring to:

  - Conduct Recovery-Oriented Quality Improvement monitoring of Network Service Providers,
  - Provide follow-up training and technical assistance to enhance recovery management approaches and practices to Network Service Providers and provide technical assistance in collaboration with the Department to any Network Service Providers with a cumulative average score of less than 4.0 across all recovery domains, and
  - Provide training and technical assistance to expand peer-based recovery services in Network Service Providers and Recovery Community Organizations in the Northeast/North Central Regions.
- Include findings from the Recovery-Oriented QI Monitoring Tool in Network Service Provider monitoring reports and include all elements of the facility tour, policy and procedure review, person served interviews, surveys, clinical chart scoring outcomes, staff interviews, and where applicable, review of peer specialist staff job description(s). Reports shall be submitted to the Network Service Provider within 30 days of the site visit.

Resources

Network Service Providers are encouraged to research the following recovery-oriented promising practices as examples of effective implementation:

Recovery Support Bridgers/Navigators - Certified Recovery Peer Specialists (CRPS) are utilized to assist individuals successfully transition back into the community following discharge from a SMHTF, CSU or Detox. The CRPS engages the individual while still inpatient and provides support and information on discharge options. They participate in discharge planning and assist the person in identifying community-based service and support needs and build self-directed recovery tools, such as a Wellness Recovery Action Plan (WRAP). The CRPS then supports the individual as they transition to the community. More information on WRAP may be accessed at: http://mentalhealthrecovery.com/

Care Transition Programs® - This intervention utilizes a Transition Coach to preferably meet an individual in the acute care setting to engage them and their family (as appropriate) and sets up in-home follow up visits and phone calls designated to increase self-management skills, personal goal attainment, and provide continuity across the transition. More information on the Care Transition Programs may be accessed at: http://caretransitions.org/

Behavioral Health Homes - The SAMHSA – HRSA Center for Integrated Health Solutions has proposed a set of core clinical features of a behavioral health-based health home that serves people with mental health and substance use disorders, with the belief that application of these features will help organizations succeed as health homes. This resource may be accessed at: http://www.integration.samhsa.gov/clinical-practice/CIHS_Health_Homes_Core_Clinical_Features.pdf

Reducing Avoidable Readmissions Effectively - The RARE Campaign in Minnesota was established to improve the quality of care for persons transitioning across care systems and to reduce avoidable readmissions by 20%. Five areas were identified as a focus of these efforts:

- Patient/Family Engagement and Activation,
- Medication Management,
- Comprehensive Transition Planning,
- Care Transition Support, and
- Transition Communication

For more detail, the RARE Campaign published recommendations on actions to address the above areas of focus which can be accessed at: http://www.rarereadmissions.org/documents/Recommended_Actions_Mental_Health.pdf

Telehealth - Technology presents another promising practice in coordinating care, specifically related to access. For example, the Department of Veterans Affairs piloted a care coordination/home telehealth initiative that continually monitored veterans with chronic health conditions. Vital signs and other disease management data was transmitted to clinicians remotely located. The pilot reported reductions in hospital admissions and length of stay.

Wraparound - Wraparound is an intensive, individualized care planning and management process for individuals with complex needs, most typically children, youth, and their families. The Wraparound approach provides a structured, holistic and highly individualized team planning process which includes meeting the needs of the entire family. The philosophy of care begins with the principal of "voice and choice", which stipulates the child and family perspective and drives the planning. The values further stipulate that care be community-based and culturally and linguistically competent. The staff to family ratio typically does not exceed one Wraparound facilitator to ten families. More information on Wraparound may be accessed at: http://nwi.pdx.edu/.

Relevant Websites:

- http://www.williamwhitepapers.com/
- https://www.samhsa.gov/brss-tacs
- https://inaps.memberclicks.net/assets/docs/RTP%20Next%20Steps%20Manual.pdf
- https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf
- DBHIDS Peer Support Toolkit

Recovery Management Practices will be administered according to DCF Guidance 35, which can be found at following link using the applicable fiscal year: http://www.myflfamilies.com/service-programs/samh/managing-entities/.