Florida Department of Children and Families

Office of Substance Abuse and Mental Health

Recovery-Oriented Quality Improvement Monitoring BLUEPRINT

June 2020

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ACKNOWLEDGMENTS

The *Recovery-Oriented Quality Improvement Monitoring Protocol* and this *Blueprint* publication were created by the Florida Certification Board through funding provided by Florida's Opioid State Targeted Response Project (STR) and Florida's State Opioid Response Project (SOR) through Contract LH 290 (Florida Department of Children and Families, Office of Substance Abuse and Mental Health).

A special acknowledgment goes to Wesley Evans, Statewide Coordinator of Integration and Recovery Services, Florida Department of Children and Families, whose passion and perseverance have carried forward the recovery vision for the State and the realization of this quality improvement protocol.

Recommended citation:

Waters, P., Pearson, M., & Piper, N. (2020, June). *Blueprint for Recovery-Oriented Quality Improvement Monitoring.* Tallahassee, FL: Florida Department of Children and Families, Office of Substance Abuse and Mental Health.

Section 1. Recovery-Oriented Quality Improvement Monitoring

Introduction

The Florida Department of Children and Families, Office of Substance Abuse and Mental Health, in partnership with Florida leaders and behavioral health stakeholders, has worked collaboratively in the past couple of years to shape the vision and future of Florida's prevention, treatment and recovery support systems. The desired end goal is a fully operationalized ***recovery-oriented system of care (ROSC).*** To this end, the State has worked with people, organizations and communities to:

- Increase knowledge and understanding of recovery.
- empower people with mental health and substance use conditions to lead their own recovery.
- Influence recovery focused policy, practice and service development.

In 2016, Florida law was augmented to specify that Florida's behavioral health services are to be based on *recovery-oriented principles* (Ch. 2016-241, Laws of Florida). This legislation provided statutory support for the values and principles that underpin a recovery orientation as well as the implementation of recovery-oriented practices throughout the State. Importantly, it fosters State priorities and regional differences while ensuring that communities and systems deliver high-quality care and services based on a recovery-orientation.

As part of the evolving ROSC initiatives, a unique program emerged – **Quality Improvement Monitoring for Recovery-Oriented Systems of Care**. This innovative program uses evidence-based measures of recovery principles and applies these measures to service provider organizations. A recovery-oriented quality improvement component was added to the State's traditional quality improvement monitoring practices for contracted mental

ROSC PRINCIPLES

- Strengths-based approaches that promote hope
- Anchored in the community
- Person- and family-directed
- Supportive of multiple pathways toward recovery
- Based on family inclusion and peer culture, support, and leadership
- Individualized approaches that are holistic, culturally competent, and trauma informed
- Focused on the needs, safety, and resilience of children and adolescents
- Approaches that encourage choice

health and substance use provider organizations. This *Blueprint* details the rationale, procedures, and tools used for this new component.

What is Quality?

There is no universally accepted definition of 'quality' within healthcare. The Institute of Medicine provides an often used definition:

> *Quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.*[1]

The Institute of Medicine has also identified six dimensions of healthcare quality.[2] The following are the six dimensions defined as they fit a recovery orientation.

1. **Safe:** Avoiding harm to persons served from care that is intended to help them, particularly in the case of psychotropic medications and medication-assisted treatments. Trauma-informed care is another aspect of safety.
2. **Effective:** Providing services based on evidence produces a clear benefit by using a recovery orientation.
3. **Person-centered:** Establishing a partnership between service providers and persons served to ensure care respects the desires of service recipients, individual rights, treatment options, treatment planning, recovery planning, medications, etc.
4. **Timely:** Reducing wait times for services, offering pre-treatment services, and use of peer specialists/outreach workers for outreach and connection to a variety of services as appropriate.
5. **Efficient**: Making use of a variety of recovery support services, including peer specialists, to move costs away from more intensive services, as appropriate.
6. **Equitable**: Providing care that does not vary in quality because of a person's characteristics such as race or ethnicity, diagnosis, ability to pay, or co-occurring conditions.

What is Quality Improvement?

As with the term 'quality', there is no single definition of ***quality improvement***. However, a number of definitions describe it as ***a systematic approach that uses specific techniques to improve quality***. Consistency in how the approach is used is very important.

Quality improvement (QI) is a management process that encourages all healthcare team members to continuously ask the questions, "How are we doing?" and "Can we do it better?"

It is assumed that behavioral health service agencies have quality improvement (QI) processes. It is likely that the QI processes are at varying levels of intensity and utilization. These processes:

- are internally driven and conducted by the agency staff actually providing or supervising the service (programmatic or administrative)
- provide opportunities for all staff to use data and make improvements in their day-to-day work environment, and
- are based on sound principles of evaluation, is regular and ongoing, and meets a set of specified standards.

Foundation of Quality Improvement

Quality Improvement is a proven, effective way to improve care for persons served and improve practice for staff. In the healthcare system, there are always opportunities to optimize, streamline, develop and test processes. QI should be a continuous process and an integral part of everyone's work, regardless of role or position within the organization.

Quality improvement draws on a wide variety of methodologies, approaches and tools. However, many of these share some simple underlying principles to help improve quality through an:

- understanding the problem, with a particular emphasis on what the data tells you.
- understanding the processes and systems within the organization – particularly the service pathways – and whether these can be simplified.
- analyzing the demand, capacity and flow of the service.
- choosing the tools to bring about change, including leadership and clinical engagement, skills development, and staff and participation of the persons served.
- evaluating and measuring the impact of a change.

The State's Role in Quality Improvement

The Florida Department of Children and Families, Office of Substance Abuse and Mental Health, plus the State's seven Managing Entities, have a specific role in contracting for quality services and ensuring that quality improvement approaches are being used to redesign and enhance services.

The State's role includes:

- building measures of quality and safety into contracting specifications and, where appropriate, incentives and penalties.
- putting in place quality improvement monitoring strategies.
- emphasizing quality and safety in evaluating current and potential providers.
- looking at governance and leadership on quality and safety, including policies and procedures.
- assessing how care is provided on the ground, and how the culture and values of the organization are expressed in behavior.

Framework

Knowledge Base

The Recovery-Oriented QI Monitoring Protocol is a comprehensive, evidence-based service monitoring and development process. It was established after extensive research into current literature on the essential elements of a recovery-oriented service system, publications on system transformation initiatives, and evidence-based recovery measures for systems, organizations and individuals.[3, 4] The monitoring protocol and instruments incorporate research-based elements and recognized standards of care.

The recovery-oriented system of care is a framework designed to address the multidimensional nature of recovery by creating a system for coordinating multiple systems, services, and supports that are person-centered and build on the strengths and resiliencies of individuals, families, and communities.

Philosophically and practically, the framework of the QI protocol:

- encourages behavioral health service providers to work in partnership with the Department of Children and Families towards recovery-focused services.
- supports learning and reflection leading to measurable improvement.
- helps build the problem-solving, teamwork, communication, values and skills required to support recovery.
- helps service providers to celebrate success and good practice as well as make improvements.
- helps services sustain the improved standards of performance, achievement, and success.
- elicits and values service user reported outcomes and experiences.

In selecting specific measures of recovery and evidence-based instruments, it was important to identify instruments designed to:

- ***measure individual's recovery*** that could be useful to service providers in monitoring recovery status and change, and in detecting opportunities for improving aspects of recovery.
- ***measure the recovery orientation of services*** and monitor the status and change of the recovery orientation particular to an organization's services, in comparing services, and in detecting opportunities for improving the recovery orientation of services.

Two instruments were selected for this protocol - one measures individuals' recovery and the other measures the recovery orientation of services.

1. **Recovery Self-Assessment (RSA-R)**[5] is a suite of four instruments that contain concrete, operational items to help program staff, persons in recovery, and significant others to identify practices in their mental health or substance use agency that facilitate or impede recovery.

   RSA – Four Versions

   1. **Person in Recovery**
   2. **Family Member/Advocate**
   3. **Provider**
   4. **CEOs and Agency Directors**

   The RSA-R has been widely used and researched for effectiveness. It is free to use and endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA). The RSA-R is brief and self-administered. The Person in Recovery and Provider versions were selected for this QI Protocol.

2. **The Recovery Oriented Practices Index (ROPI)**[6] measures practice in relation to recovery-promoting values. This instrument was developed by the New York State Office for Mental Health. The ROPI has been adapted for use in this QI monitoring initiative. It has 20 items, each of which is assessed on a 5-point Likert scale – which makes it useful for external reviewers (as opposed to self-assessment). It covers the following domains:

   a. Meeting basic needs
   b. Comprehensive services
   c. Customization and choice
   d. Consumer involvement / participation
   e. Network supports / community integration
   f. Strengths-based approach
   g. Source of personal control / self-determination
   h. Recovery focus

This QI protocol uses an adaptation of the ROPI. This was patterned after the *Scottish Recovery Indicator (SRI)* which was initially based on the Recovery Oriented Practices Index. The Scottish

Recovery Network used the SRI to create a web-based service development tool to support and develop recovery-focused approaches in Scottish mental health services.[7]

The first pilot Recovery-Oriented QI Monitoring visits were conducted from May 2018 to September 2019 in all regions within the Department of Children and Families. Focus groups were held with State monitoring personnel in the fall of 2019 to gather data about lessons learned and solicit recommendations for modifications of the protocol and/or the monitoring instruments. This Blueprint is the culmination of the initial principles and practices of the protocol, the lessons learned, and recommendations.

FRAMEWORK: RECOVERY-ORIENTATION QI MONITORING

KNOWLEDGE BASE

- Analysis of credible, research-based evidence of measures that relate to recovery-oriented outcomes
- Creation of new monitoring tools founded upon research-based recovery measures
- Use of learnings from pilot QI monitoring visits in strategy and design modifications

INNOVATION

- State-level modification to create uniform QI monitoring practices for ROSC
- Incorporates multiple levels of assessment, including persons served
- Use of Recovery-Oriented Quality Improvement Specialists which demonstrates the value of lived experience in state monitoring activities
- Fosters a shared understanding of how recovery is operationalized in policy and practice
- Inclusion of Medication-Assisted Treatment (MAT) as a recovery-oriented measurement component

PARTNERSHIP

- Base organization review on a foundation of partnership
- Conduct review from a non-regulatory perspective
- Use strategies to help motivate service providers and gain their commitment to adjust service provision to more fully encompass a recovery orientation

Innovation

There are many aspects of the Recovery-Oriented QI Monitoring protocol that are unique and innovative.

➔**State-level modification of QI monitoring practices for a recovery focus.** This new protocol is implemented statewide. State leaders made a commitment to building system capacity for recovery-oriented services and making incremental changes to policy and practice that can foster sustained change. Each of the six state regions hired a Recovery-Oriented Quality Improvement Specialist to champion the new QI protocol. After a period of testing and refinement, the intent is to integrate the new protocol into the state's usual contract and quality improvement monitoring process to operationalize a ***recovery-oriented system of care*.** This system-level "roll out" of the new protocol poses many benefits to the State.

SYSTEM BENEFITS

- Adapt or develop district and facility data collection tools to capture essential data on recovery-oriented performance indicators.
- Strengthen the capacity of the QI team to generate and use data for recovery-oriented system improvements.
- Strengthen the capacity of district staff to review data and act upon the information.
- Address structural, system and human resource barriers by providing financial, technical or material resources to further recovery-oriented system transformation.
- Establish a baseline and track system and facility performance on the prioritized recovery indicators.
- Continuously identify and promote the standards and indicators that providers can use for quality improvement and quality control of the prioritized indicators of recovery-oriented care and outcomes.
- Benchmark best practices to reflect system and organizational improvements.

➔**Incorporates multiple levels of assessment.** Data is the foundation for quality improvement initiatives. Using a variety of data sources, evaluated individually and aggregated at the practice level, can lead to a better understanding of findings. Ignoring the multilevel nature of recovery-oriented service data can lead to erroneous inferences about care quality.

The Recovery-Oriented QI Monitoring protocol assesses recovery indicator data at four separate levels. The Final Report and feedback given to the organization is based on analysis of all four sources.

Facility Review	Clinical Record Review	Staff Interviews	Interviews with Persons Served
•To determine the existance of and compliance with policies, procedures and standards in areas to be reviewed.	•To review electronic and/or hard copy documentation (e.g., clincal records) to determine application of desired service methods in important clinical documents such as treatment and recovery support plans.	•To determine employee knowledge of and compliance with the policies, procedures, and standards under review.	•To verify the application of the desired practices as reported by the persons receiving services.

➔**Recovery-Oriented Quality Improvement Specialists**. One of the unique components of this QI Program is the use of Recovery Oriented Quality Improvement Specialists. A new position has been created within State regional offices which uses Certified Recovery Peer Specialists to bring the value of lived experience into the QI monitoring Team. In addition to their responsibilities for QI Monitoring activities, these individuals also have responsibility for:

- Brokering training, technical assistance, and consultation for organizations related to recovery-oriented practices and the expansion of medicated-assisted treatment.
- Fostering the implementation and enhancement of recovery approaches and services within the local system of care.

➔**Inclusion of Medication-Assisted Treatment (MAT) as a recovery-oriented measure.** Medication-Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-person" approach to the treatment of alcohol and opioid use disorders. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MAT can help sustain recovery.[8] Therefore, MAT should be offered as a part of

a comprehensive approach to recovery, particularly for those individuals with opioid use disorders.

Opioid misuse has had a massive impact on American society. Increasing opioid overdose deaths, illicit opioid use, and prescription opioid misuse have led to a public health crisis. A body of science-based findings has emerged in regard to the successful treatment of opioid addiction. The medical and scientific communities have concluded that MAT for opioid addiction is not just an option, but is the recommended modality of treatment for moderate to severe opioid addictions. Medication for opioid use disorders should be successfully integrated within a variety of treatment settings.

The review of MAT in this protocol does not include an evaluation of the effectiveness of MAT services provided (such as types of medications used, service protocol, etc.). This would be beyond the scope of practice of the QI Monitoring Teams. The aim of the review in this QI monitoring is to determine:

- if MAT was offered to service recipients who have been assessed and are eligible for MAT,
- if the organization discussed with the service recipient the risks, treatment options, and requirements for successfully completing treatment, and/or
- if referrals were made to other providers for MAT when the organization was unable to offer MAT services.

Partnership

The third unique aspect of the Recovery-Oriented QI protocol is the heart of the initiative - ***Partnership***. This revolves around the direct connections between the QI initiative staff and staff of service provider organizations. The service provider's organizational leadership team and front-line staff members are engaged throughout the QI monitoring process and the value of a recovery orientation is reinforced.

An important aspect of the QI process is that its approach is not based upon compliance ratings. The first monitoring visit establishes a baseline of information from which the organization can choose specific actions to advance a recovery orientation in identified aspects of policies and services. The intent of this visit is to raise the profile of recovery and provide a framework to discuss how services can best support individual recovery.

Connecting recovery-oriented expectations to routine practice is an expected outcome of the QI Monitoring Review. Operationalizing recovery-oriented principles takes a concerted and systematic approach. It is common for service providers to believe that they are already implementing recovery-oriented approaches or that their practice is farther along than it

actually is.[9] This is a particularly common hurdle in a system in which recovery-oriented terms and concepts are not entirely new or may be vague.

Providers may believe they are already implementing recovery-oriented approaches when they are implementing some—but not all— relevant aspects of a particular practice. If expectations for using recovery-oriented approaches are not connected to concrete behaviors, it can be difficult for providers to gauge the extent to which they are truly implementing recovery-oriented principles and practices.

The use of a motivational approach within the spirit of partnership and collaboration engages the service providers in conversations that facilitate change. The assessment of how services can be improved, as well as understanding organizational readiness for change, will help to craft a plan, if needed, for the provision of technical assistance.

QI Monitoring staff are tasked with linking technical assistance to activities that support identified areas for improvement. This type of support for issues identified as part of a QI initiative are a critical but often overlooked component. Examples of potential areas for technical assistance include:

- initial and ongoing training
- selection of recovery-oriented assessment and treatment practices
- strategies for engagement of persons served along the full continuum of care
- use of data systems to monitor progress
- evaluation strategies within organizational QI initiatives to assess ongoing effectiveness

What Can You Expect from this Blueprint?

This Blueprint provides foundational knowledge, as well as step-by-step instructions, that are necessary for the administration of the **Recovery-Oriented Quality Improvement Monitoring** protocol.

This document is divided into three main sections:

- **Introduction** — This current section with the background and philosophy for promoting recovery-oriented quality improvement through this unique QI protocol.
- **QI Monitoring Protocols** — Step-by-step details presented in the sequence of the structured QI protocol including discussions, tips, and examples in select components.
- **Appendices for QI Monitoring Scoring and Tools** — Step-by-step presentation of scoring methods for clinical record review and client interviews, plus final cumulative scoring. A template and instructions for the construction of the Final Report are also provided.

Tools

The Recovery-Oriented QI Monitoring Protocol uses a variety of tools to help identify the source of quality issues surrounding recovery indicators and focus improvement efforts. Each tool has its own purpose, and it is important to select the right tool for each analysis. The use of tools is indicated in the protocol section by the toolbox icon.

The following table lists the QI tools described in this Blueprint and when to use them for data collection. It is important to note that all instruments and the responses and scores to each are used in team discussions after the site visit and in the creation of the Final Report

TOOLS	WHEN TO USE THE TOOL
Measuring Recovery-Oriented Principles and Practices Tool ***Where to Find Information for Scoring Quick Reference***	Prior to the site visit to become familiar with recovery indicators and where you may find data in clinical records Use onsite as companion guides for scoring
Scoring Tool for Recovery & MAT Elements in Clinical Record	Onsite during the scoring of clinical records
Recovery Self-Assessment (RSA) – Person in Recovery version	Onsite during interviews of persons served
RSA-R Scoring Tool for Person in Recovery version	Onsite during team analysis of data
Organizational Self-Assessment: Peer Support, Culture, and Leadership	Onsite; completed by provider staff or completed as a part of a staff interview
Recovery Self-Assessment (RSA) – Provider version	Onsite; completed by provider staff
Cumulative Scoring Tools for Recovery-Oriented Principles	Onsite to determine a set of cumulative scores for all recovery-oriented indicators for the organization
Final Report Template	Post site visit to write the Final Report

Summary

The QI Monitoring protocol presented in this Blueprint is supported by both emerging research surrounding recovery measures and consensus from persons implementing the Recovery-Oriented QI Monitoring protocol in Florida's pilot sites. It is important to remember that the Blueprint will likely need to be updated in the future as the knowledge base expands. For now, this initiative aims to raise the profile of recovery in Florida and provide unique insight into how behavioral health service providers are responding to the need to be more recovery-focused.

Section 2. Recovery-Oriented QI Monitoring: Methods

Introduction

The review and monitoring of a service Provider for evidence of recovery-oriented principles includes three distinct stages: ***pre-site visit, onsite,*** and ***post-site visit*****.** Each of these components have protocols that if adhered to, will allow the monitoring Team to work more efficiently. The process and sequence of events of a monitoring visit are intentionally deliberate.

The recovery-oriented QI monitoring approach assumes that the capability and responsibility for change lie within the service Provider organizations themselves**.** The role of the monitoring Team in facilitating change is:

- to provide helpful feedback to enhance service Providers' motivation and commitment to adjust the services towards a recovery orientation; and
- to assist the agency by identifying resources for change, including technical assistance that may be provided by Team members.

While the knowledge, skills, and attitudes of the Team members are of course important, the success of site visits can be greatly enhanced by clear and effective communication between the monitoring Team members themselves, as well as between the monitoring Team and the Provider agency. Remember, the aim of the recovery-oriented QI review is to engage, assess, and motivate behavioral health organizations to provide services that:

- increase rates of service retention
- reduce rates of service disengagement and administrative discharge
- provide a menu of service options so that care is both individualized and incorporates family members and other important allies, as desired
- use assertive approaches in helping people remain connected to natural community-based supports
- enhance peer-based recovery support services in the treatment context, and
- provide culturally competent services

TIPS

The Importance of Teamwork

1. **Common purpose**. It is the ability of the members to embrace the common purpose that makes great Teamwork. Individual objectives are important, but Teamwork requires shared objectives, too. This means linking and aligning singular goals to the bigger picture.
2. **Collaboration** is all about working together. Collaboration is typically characterized by strong relationships, trust and mutual respect and it will usually require an overt Team process to promote, support and encourage 'sharing'.
3. **Communication** is an important element of collaboration. Open, honest and timely, should be set as a core Team value. A process needs to be in place that encourages and structures communication. Effective communication is a "two-way" process which involves sharing information, insights and active listening. One of the major keys to improvement among monitoring Teams is breaking down communication barriers which exist when each Team member is doing discrete tasks.
    - A big part of communication is **Conflict Resolution.** Conflict isn't necessarily a bad thing. Balancing opinions and differences requires well-developed Team skills, particularly the ability to resolve conflict when it does happens, and the ability to keep it healthy and avoid conflict in the day-to-day course of Team working.
4. **Contribution**. The foundation of Teamwork is leveraging the collective actions of the Team. Contribution requires that members understand their roles, goals and what is expected of them, and everyone feels comfortable and confident.
5. **Coordination**. Coordination is what melds all of these elements together to make the individual components work together in harmony. Effective coordination will require planning, monitoring and ongoing organization to ensure that the process is much more than a series of unrelated work streams.

Pre-site Visit Protocols

The monitoring process begins before the Team goes onsite and starts with the forming of the QI monitoring Team. Team members should have an opportunity to meet, become familiar with each other, share their understanding of recovery-oriented principles, and ask questions. These type of interactions are part of the Team-building process and can contribute to more effective working relationships when the Team is onsite.

Thoughtful preparation for the site visit is essential. All Team members need to understand the process, expectations, and objectives for the visit. The key to a successful site visit is a professional, structured, and consistent approach. Although clinical practices vary slightly across organizations under review, the fundamentals remain the same. Thus, preparation, organization and communication are crucial elements.

Establishing and Preparing the Recovery-Oriented QI Monitoring Team

- **Selection/Appointment of Team members** – The number of members and actual makeup of the Team may vary from region to region. However, at a minimum members will include staff from the Department's regional office or the Managing entity and the Recovery Oriented Quality Improvement Specialists.

- **Selection of the Team Leader** – A Team Leader will need to be identified. This person plays many important roles: approves which Team members serve in which roles; serves as the primary contact for the Team with the Provider; drafts the introductory letter to the Provider; leads the onsite Entrance Interview; facilitates the onsite Exit Interview; oversees the completion of the Final Report; and, coordinates all follow-up communication, including Technical Assistance with the Provider.

- **Recovery-oriented QI Team Meetings** – The Team should meet at least two (2) or more times prior to the site visit to:

    - facilitate introductions, role assignments (both pre-site visit and onsite), and a work plan.
    - discuss logistics (travel, arrival time, where to park, expected length of stay, etc.), sequence of monitoring activities, and to confirm role assignments.
    - increase familiarity with monitoring tools, to include opportunities to practice using them.

- **QI Tool Reviews** – It is the responsibility of all Team members to familiarize themselves with the QI monitoring tools. This may entail "practice sessions" with the tools, ideally

pairing someone with experience with a specific tool with someone with less experience. The entire Team itself should be involved to try and replicate the onsite scoring and decisions they will have to make. The Team Leader should assess each Team member's familiarity with the tools they will be using.

- **Review of Provider Policies and Procedures** – As much as possible, written Provider materials should be requested, received, and reviewed by the monitoring Team prior to the visit. This helps the Team to gain some familiarity with the Provider and allows more time for other tasks to be done onsite. It is important to be specific and the Team should only request the materials they want, these policies and procedures include:
    - Treatment/Recovery plans
    - Discharge/Aftercare plans
    - Discharge criteria (successful and unsuccessful)
    - Community integration services
    - Job descriptions (these must include Peer Specialists and Peer Specialist Supervisor)

Preparing the Provider Agency

- **Introduction Letter to the Provider** – The Team Leader is responsible for preparing this letter. It provides the details surrounding preparation for the monitoring site visit, as well as on site procedures. The letter should introduce the new review protocol related to recovery-oriented principles and practices.
    - The Provider should be made fully aware of the monitoring process, to include; days/times the Team is expected to be onsite, which programs/locations will be visited, the identification of Team members, how clinical files will be selected, that interviews will include staff members and persons-served, and any other information relevant to the visit.
    - A brief, but focused face-to-face meeting that occurs as soon as the Team goes onsite must also be included in planning activities. This is called an Entrance Interview and it will allow for all parties to be introduced to one another.
- **Request for Provider Materials** – Requests for the material that the Team wishes to review prior to going onsite should be done in a manner that allows the Provider adequate time to gather the information and send it to you. Targeted specific requests of only needed material helps both the Provider and Team.

- **Request to Interview Provider Staff** – Provider should be notified that interviews with staff from a mixture of job classifications will be part of the monitoring process. This early notification helps the Provider in their planning and scheduling to make staff available to the Team.

- **Reminder to Provider** – The Team Leader should communicate with the Provider 48-72 hours prior to the visit reminding them of the day, time, and location that the Team will arrive. Be sure to ask if there are any updated special conditions such as safety or security precautions regarding your Team's visit.

Onsite Protocols

The QI Monitoring Team's onsite presence has two key components that are critical to the success of visit. First, the Team's skills and abilities in carrying out tasks such as reviews of files, interviews with persons-served, interviews with Provider staff, observations of the environment, all in conjunction with the use of the monitoring tools.

Secondly, individual Team members, as well as the Team as a whole, must conduct the review in a professional, respectful, knowledgeable, and supportive fashion. Every interaction has the potential to add to the desired goal of establishing a partnership to promote recovery-oriented principles and practices.

Onsite Monitoring Process

The QI Monitoring Team must develop a well-defined "plan of action" for the onsite monitoring activities, one in which all Team members are part of developing. An agenda should be developed and agreed upon in advance by the Team members. The agenda should identify the order of the specific tasks and who is responsible for them, as this will contribute to a more focused and organized process once onsite.

The process of conducting an effective onsite monitoring visit goes beyond the organized completion of assigned tasks and reviews. Team members should remain aware that not only will others be observing what they do during the monitoring visit, they will also be assessing how the Team members conduct themselves both individually and as a team. Teams around the State of Florida who participated in the initial Recovery-Oriented QI site visits have identified several key elements that help promote the purpose of the visit.

- **Communication of the recovery-oriented Vision** – It is the responsibility of each Team Member to continuously reference the associated recovery-oriented principles and practices as they attend to their onsite monitoring tasks. These types of discussions can increase awareness that recovery-oriented is more than just the inclusion of peer services.

  Transparency During the Monitoring Visit – The Team should make every attempt to be open and accessible to Provider inquiries throughout the visit. This will include

answering questions, clarifying the Team's purpose for being there, as well as offering information and guidance regarding recovery-oriented principles and practices.

- **Maintaining the Integrity of the Recovery-Oriented QI Monitoring Process** – The Recovery-Oriented QI Monitoring Team is a sub-component of the compliance site visit. It is important to clarify their own purpose and focus for being onsite. Some Providers/Provider staff may be inclined to view the Monitoring Team as part of the compliance site visit that is inclusive of potential sanctions/required corrective actions; therefore, it is important to continuously clarify your intentions to assist in their efforts to promote recovery-oriented principles and practices.

Entrance Interview

The Entrance Interview is a meeting between the QI Monitoring Team and the Provider, which is designed to make introductions, establish lines of communication, and clarify the Team's plan of action. Provider staff, from the top administrators to the frontline workers, will have varying pre-conceived ideas and attitudes about what to expect from a monitoring visit. This is the Team's first face-to-face opportunity to communicate the scope and purpose of their visit.

- **Entrance Interview Process** – This interview is the first onsite activity. The Team meets with the designated Provider staff to briefly go over the agenda for the visit. This also consists of introductions between Team members and Provider staff in attendance. The Provider will oftentimes take the opportunity to segue from this initial meeting to offer a tour of the facilities/programs and introduce the Team to various Provider staff on those units. There may be restrictions of movement/security protocols that need to be identified, as well as determination of the designated Provider staff who will serve as contacts for specific areas.

  This meeting is also where the Team Leader confirms the location where the Team can assemble and conduct their work. As much as possible, this area should be as private and free from distractions as possible, keeping in mind that reviews of confidential information may be done there.

Clinical Record Reviews

This part of the monitoring visit requires time and patience. This is usually the single most time-consuming task of the visit, even for Team members who are familiar with client records. Since it is "best practice" to review as many files as possible, more than one Team member should be assigned to review client records. Remember, each Provider has their own system for organizing their files, so it may take extra time to become familiar with their process.

TOOLS

- ***Measuring Recovery-Oriented Principles and Practices Tool***
- ***Where to Find Information for Scoring Quick Reference Sheet***
- ***Scoring Tool for Recovery & MAT Elements in Clinical Record/Case File***

- **Purpose** is to review a source of potential evidence of recovery-oriented principles and practices. What is recorded by the Provider in the files ideally should match with what is reported by persons-served, what is reported by Provider staff and what is observed by the Team.

- **Selection of the Monitoring Team Staff to do the Clinical Record Reviews** – Choosing Team members who have past experience in reviewing these type of files will help expedite the review of the files in the time allotted. Team members must know how to recognize recovery-oriented principles and practices within the clinical record. The tools listed above provide guidance on the specific elements for review and where these might be found in the clinical record. Appendix A in this Blueprint provides specific instruction about how to use these tools.;

- **Selection of Clinical Records** – Clinical records can be presented as hard copy files or electronic health records. The selection of the clinical records is a critical part of the process. It may be easier to have the Provider select the **clinical records,** however, it is "best practice" for the Monitoring Team to select them so as to ensure that they are randomly selected. There are advantages to asking the Provider to select 1-2 records (in addition to the minimum number the Team is already selecting) that they believe reflects their best services. This helps the Provider to feel included in the process.

- **Number of Clinical Records** – The larger the number of clinical records reviewed will result in a greater confidence in the findings by both the Team and the Provider. This "ample sample" is typically greater than 10.. If the Team notes any significant positive or negative trends within a certain section of the record, it is perfectly acceptable to select a few more to specifically look at that section to help justify the findings. The Team should alert the Provider that they may be selecting more records during the visit.

  One important note: Most monitoring visits will be of similar lengths of time, even though the number of persons served by a Provider can vary greatly. This means that the same number of client records reviewed for one program will reflect a greater or lesser percentage of the overall records when compared to the same number of records for a program of a different size. In an effort to increase confidence in the findings it is important to plan to review as many records as possible during a visit. Set a minimum number for review, however. This allows for appropriate allocation of time and resources for this component.

- **Types of Client Records** – It is best to review clinical records that show service delivery within the last 12 months, as services provided earlier that may not reflect the current practices of the Provider.

  Select several records from each of the following:

  - open/currently receiving services,
  - closed/successful completion of services, and
  - terminated/unsuccessful completion of services.

- **Care and Safeguarding of the Records** – The Team must ensure that at no time that any clinical record is left unattended for any amount of time. These records contain highly confidential information and they should be returned to the designated Provider staff and area when the reviews are completed.

- **What Sections to Review** – Focus should be on identifying recovery-oriented principles in the following sections:

  - **Background and Medical History:** A summary of the person's medical and behavioral health history is compiled. A biopsychosocial evaluation takes into account not only the physical health of the client, but also the person's perception of self and his or her ability to function in the community. Specific life domains are evaluated such as legal issues, family, social and relationship factors, work or education, etc. that can affect treatment outcomes.

  - **Assessment:** Various types of commonly provided assessments include a physical examination, psychiatric evaluation, substance use diagnostic and laboratory tests, and an assessment of the extent of long-term impairments to normal functional living skills. At the conclusion of the assessment process, a narrative summary is created to bring together the results and then briefly describe the proposed treatment(s), rehabilitative service(s) and support service(s) to be provided.

  - **Treatment Plan:** This type of plan is the written roadmap for providing specific individualized treatment and supportive interventions, including medication, to lead to the achievement of desired outcomes. Plans are required to be reviewed at specific intervals; updates to the plan occur as needed. Behavioral health programs are required to have "treatment plans" that outline all the services for each person-served. Treatment plans should always include the individual's input at all phases; however, in cases where the individual may be temporarily unable to participate in its development, the Provider staff still has the responsibility to complete a treatment plan.

- **Recovery Plan:** This type of plan, although not typically required in many behavioral health programs, are considered a best practice in a recovery-oriented approach. It is also a written roadmap detailing goals and objectives towards the individual's desire for their recovery. One significant difference in recovery plans from treatment plans is the individual has primary responsibility for the development, implementation, and revisions of the plan within a context of help from peers and other relevant staff.

- **Daily Progress Notes:** Daily notes document the person's ongoing progress resulting from the implementation of his/her individualized treatment/service plans. The progress notes will describe the person's progress as it relates to specific measurable objectives.

- **Discharge/Aftercare Plan:** Discharge planning should begin with the person's admission to services. Since it is anticipated that each person will not be actively receiving services from the Provider at some point, a collaborative process begins to identify the person's continued recovery after discharge. A ***Recovery Plan*** may go beyond the typical discharge plan to identify the elements that the person identifies as needed to keep structures in their lives that actively support their health and well-being. This includes identification of triggers, warning signs, and establishing a plan for crisis situations. Other plans that indicate continuity of care might be an Aftercare Plan or a Case Management Service Plan.

- **Discharge Summary:** A narrative that completes the treatment and discharge process by summarizing the initial areas of concern, services rendered, outcomes, and anticipated progression of recovery. This summary is done whether the person's completion of services is deemed successful or unsuccessful.

- **Scoring the Clinical Records.** The Scoring Tool used for clinical records goes hand-in-hand with the *Measuring recovery-oriented Principles and Practices Tool.* The Scoring Tool has the same layout by with eight domains of recovery elements along with a **scoring rubric.** A rubric is a type of matrix that provides scaled levels of achievement or understanding for a set of criteria or dimensions of quality for a given type of performance. It consists of a rating of performance, usually along a 5-point scale, for example from 'Very poor' to 'Excellent.' Appendix A details the use of the ***Scoring Tool for Recovery & MAT Elements in Clinical Record/Case File.***

TIPS

It is important to identify and acknowledge when a Provider has evidence of recovery-oriented principles. If you are unable to find a particular item in a clinical record, *ask Provider staff to help you locate it!*

- If the necessary item *is in the clinical record,* this Increases accuracy and lends more credibility to your monitoring.
- If the necessary item *is not in the clinical record,* this provides "instant feedback" to Provider staff.

Interviews with Persons-Served

This evidence acquired in the review of clinical records is complemented by the second stage of the QI monitoring process. In this stage, data is gathered by obtaining the views of those receiving services from the organization under review. The selection of those individuals the Team wishes to interview will be coordinated with the Provider. In cases where the person-served is participating in outpatient/aftercare services, notifications should be made as early as possible to allow for enough time for the individual to make arrangements to be interviewed. Since situations may occur that prevent an individual (either inpatient or outpatient) from being interviewed, Teams should work with the Provider to ensure they are able to interview their target number of persons-served and that their clinical records are reviewed.

It is expected that the Team member(s) who will be conducting the interviews also served as the reviewer(s) for the person's clinical record. It is important to be alert to the many factors that can disrupt an interview, hinder disclosure of information, or even impact on the client in such a way that they will not participate at any point in the future.

TOOLS

- ***Recovery Self-Assessment (RSA-R)***
- ***RSA-R Scoring Tool***

- **Purpose –** This part of the process is to help the people who use the service reflect on the recovery indicators and associated statements through a structured process

facilitated by members of the QI team. The RSA-R, is the tool that will be used in this QI review. This instrument has 32-items designed to gauge the degree to which programs implement recovery-oriented practices. It measures five factors: life goals, involvement in the organization, treatment diversity, choice, and individually-tailored services.

- **Ensuring Privacy** – It is critical that the person being interviewed be afforded privacy.
- **Use of Interviewing Skills** – Team members must possess excellent interviewing skills, to include the ability to; objectively seek information without "leading" the person in their responses, be conversational in their approach, and be trauma-informed.
- **Use of the RSA-R** – Team members should be familiar with the Person in Recovery instrument. It is recommended that the Monitoring Teams discuss and decide how the instrument will be used. Specifically, whether individuals will be afforded the opportunity to complete the instrument on their own or whether a Team member will ask the questions. Unless circumstances dictate otherwise, all the questions should be asked/be available to be answered.
    - Explain why the interview is necessary.
    - For the RSA-R, read questions slowly and clearly.
    - Ask questions exactly as they are written.
    - Ask questions exactly in the order they appear.
    - Use the introductory or transitional phrases as written.
    - Repeat the question exactly as written if the participant does not understand it. If clarification is needed do not offer potential answers.

TIPS

It may be necessary to help the person receiving services to understand the meaning of the RSA-R statements that need to be rated. Here are some ways to explain the intent of the instrument's statements.

➔**My basic needs are well met by this service.** Basic needs include housing, nutrition, health, finance, safety, personal care and spirituality.

➔**My goals are addressed when planning my care.** This may be rated on different interpretations. The person may have personal goals that they have never expressed. It may be that they did name their personal goals and they will rate the service on how well it has helped them address these. The rating may not be connected to whether the goal was achieved or not, simply that the journey towards it was successfully started.

➔ **I get a service that is tailored to my individual needs and circumstances**. The person will rate this highly if they can see that their personal choices were routinely considered and addressed and that their personal preferences influenced the service provision. They will need to feel staff responded positively to their unique needs and circumstance rather than requiring them to fit in with a uniform approach for service users.

➔**My strengths, skills and abilities are considered by this service.** Persons receiving services are not yet used to routinely naming their strengths in the way that they would be able to name problems. For this reason, prompting may be required as to what constitutes strengths, skills, abilities, and resources.

➔**This service helps me to feel connected to my community.** People scoring this statement highly can describe ways in which the service has helped them to remain connected to their community. The service may have supported connections that provided access to transport, housing, education, arts, sport, leisure, recreation, church or faith groups, interest groups and other community resources.

➔**People who use this service have a say in how things are done.** Persons who rate this highly will have influenced the design and delivery of the service and experienced themselves as collaborators and partners.

➔**The staff are supportive, positive and approachable.** Optimally, people using the service found the staff to be recovery focused in their practice. It may be that the person can describe specific behaviors and attitudes that led them rate it in the way they did, or equally, just having the feeling that staff are supportive positive and approachable.

- **Scoring the Interviews with Persons Served.** *The RSA-R Scoring Tool* goes hand-in-hand with the *RSA-R.* This Scoring Tool organizes each survey question into its appropriate domain for ease of analysis. You will need to use the individual's RSA-R's results along with the Scoring Tool side by side in order to properly score the assessment. Once completed, you will be provided with an overview of the individual's scores for each domain. This can assist you in identifying individual's strengths, resources, and deficits. Appendix B details the use of the ***RSA-R Scoring Tool.***

Interviews with Service Provider Staff

The interviewing of Provider staff allows for a different view of the service delivery. Staff may be able to go into greater detail verbally on their practices than what may be spelled out in a clinical record, policy or procedure. The Organizational Self-Assessment: Peer Support, Culture, and Leadership was not in the initial protocol but was added during pilot site monitoring visits. The RSA-R Provider version is under consideration for use moving forward.

TOOLS

- ***Organizational Self-Assessment: Peer Support, Culture, and Leadership – (Currently in)***
- ***Recovery Self-Assessment (RSA) – (Requested)***
- ***RSA-R Scoring Tool – (Requested)***

- **Purpose –** To review another source of evidence of recovery-oriented principles and practices. Staff may be able to go into greater detail verbally on the services that are provided. What is reported by Provider staff ideally should match with what is reported by persons-served, what is recorded by the Provider in the clinical records, and what is observed by the Team.
- **Selection of Staff to be Interviewed** – This part of the process must be coordinated with the Provider to set interviews with staff in different programs and modalities. It is preferable to interview staff at various levels within the organization, such direct service, peer specialists, clinical supervisors, and administration. Each offer a unique perspective due to their vantage point.
- **Number of Staff to be Interviewed** – The larger the number of staff interviewed will result in a greater confidence in the findings by both the Team and the Provider. It is recommended that four (4) or more be interviewed. Since there is a degree of uncertainty as to whether a certain staff member will be available, planning for these interviews should ideally be done during pre-site visit preparations so adjustments can be made if necessary. It is recommended that interviews with staff be done individually and not in any group-type fashion.

- **Ensuring Privacy** – It is critical that the person being interviewed be afforded privacy.
- **Selection of the Monitoring Team Staff to do the Provider Staff Interviews** – Team members must possess excellent interviewing skills, to include the ability to; objectively seek information without "leading" the person in their responses, be conversational in their approach, and be able to structure the interview so that staff feel more comfortable.
- **Pre-Site Visit Surveys or Questionnaires** – The use of anonymous assessment surveys is another consideration. The use of these types of information-gathering could be very useful for the Monitoring Team. The advantages include: getting responses from a larger number of staff; additional information from those who might feel uncomfortable being interviewed in-person; and, the possibility of getting the responses back before the actual monitoring visit. This strategy would have to be developed/planned and approved by the Provider.

Exit Interview

One of the most critical parts of successful monitoring in the delivery of timely and relevant information is the Exit Interview. This meeting between the QI Monitoring Team and key persons within the Provider organization occurs onsite at the conclusion of the monitoring visit. It is designed to communicate general observations only, specifically an overview of the presence and/or non-presence of monitored items.

Facilitation of the meeting requires an identified Team Leader who possesses the skills and temperament to structure, facilitate, and control a meeting that offers immediate, but limited/narrowly defined feedback.

The Exit Interview should be highly structured in order to ensure that the purpose of the meeting is achieved. Providers desire some onsite feedback on "how they did" and may be anxious, sensitive, and/or even defensive regarding the findings. Great care should be taken so that the tone of the meeting is of support, as one would expect in a partnership.

- **Purpose –** To present the Monitoring Team's observations in an organized manner that identifies, supports and encourages recovery-oriented principles and practices. Multiple benefits that can be derived from an appropriately structured meeting:
    - Gives immediate support to those best practices that were observed onsite.
    - Allows for immediate attention to incomplete or missing practices
    - Provides enough information on observed practices that the Provider may proceed with any revisions they deem necessary.
    - May reduce Provider's anxiety regarding the "findings" of the visit.

It is likely that a Provider may want certain persons at the Exit Interview (Board Members, designated staff, etc.) and may want to schedule the meeting around their availability. Every effort should be made to accommodate those type of requests, however it should be made clear that the Exit Interview should be done as close to the completion of the visit as possible.

- **Participants** – The Team Leader should know how many people will be attending.
    - QI Monitoring Team: It is recommended that all Team members attend the Exit Interview. This shows a true "Team" monitoring approach.
    - Provider: The Provider will select whom they want to attend. This may include Board Members, Peer Specialists, key administrative staff, key clinical staff, etc. Given the nature of this type of monitoring it is recommended that the Team Leader suggest that Peer Specialists participate, however that decision will be up to the Provider.
- **Structure** – An Exit Interview is planned to be structured, deliberate, and time-limited (1 hour). It has the express purpose to communicate onsite observations. The Team Leader (TL) is responsible for opening the meeting, facilitating the presentation of those findings that the Team has agreed to present, ensuring the discussions stay focused, and closing the meeting. In order to promote a more focused process that avoids unintended discussions, challenges, and/or delays, the following recommended activities are listed, in order:
    - The TL should assemble the Team approximately 30 minutes prior to the Exit Interview to briefly go over the findings, identify any significant positives and/or challenges of the Provider's service delivery, briefly review the process, and identify which Team member's will be reporting.
    - The TL is responsible for the overall flow of the meeting.
        - TL opens the meeting and thanks the Provider for the opportunity to observe (not "assess" or "review") their program(s)
        - TL states the purpose of the meeting: In an effort to promote recovery-oriented principles and practices, the Team will share what they observed. It is hoped that by identifying those areas where these principles and practices are evident, as well as areas where they did not appear to be evident, that the Provider can use that information in their service delivery.
        - TL asks everyone to introduce themselves.
        - TL states that findings are based only on the information that was available to the Team, which includes policies, procedures, as well as a

sampling of clinical files, interviews with persons-served, and interviews with staff.

- TL states that a more formal assessment of the findings, as well as any more detailed recommendations will be part of the Final Report.
- TL reminds everyone that out of respect for people's schedules, that the meeting should be concluded by the planned finishing time.
- TL asks each Team Member (who was responsible for a specific area) to share their observations. If multiple Team members reviewed an area such as clinical records, then one person can deliver the feedback.
- TL facilitates the Team's response to any Provider questions.
- TL ensures that the tone of the meeting remains supportive of the Provider and in a spirit of collaboration to facilitate change.
- TL concludes the meeting by detailing the follow-up to the monitoring visit to include planned communications, the time frame for finalization of the Final Report , and any technical assistance that may be offered and/or requested.

- **Presentation of Observations and Feedback** – How information is presented in an Exit Interview is critical to how well it may he "heard" by the Provider. Delivering feedback is far more than just the sharing of observations. Remember to reinforce that the Team is only reporting on the observed presence and/or non-presence of monitored items.

TIPS

Delivering Feedback

Here are some specific ways to increase the likelihood that feedback given will be well-received.

- Be clear and concise about your observations.
- Be supportive, making sure to state that any item that was not readily identifiable *does not necessarily mean that the desired practice is not occurring.*
- Stay focused on the section/area under consideration. It's good to allow for questions and commentary, but be careful that the focus does not go to other areas or issues.
- Avoid interpretations, assumptions, and/or explanations for why a particular item may not have been located.
- Offer ideas/suggestions if asked by the Provider, with the guidance of the Team Leader.
- Share any positive encounters you had. Sometimes a Provider will make revisions to policies and/or procedures while a Team is still onsite. Those type of pro-active responses should be noted and validated.
- Speak confidently, this can be helped by reviewing your notes prior to the interview.

Post-Site Visit Protocols

Staying focused after a monitoring visit is just as important as when the Team was onsite. Organized and timely communication between Team members and with the Provider will yield greater satisfaction in the process for all involved. During an onsite visit, each individual Team member "sees" the Provider's policies and practices through their own eyes, therefore it is important to incorporate the observations, recordings, and experiences of each and every Team members. The inclusion of everyone's input will offer the most credible assessments of a Provider's practices regarding recovery-oriented and principles.

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Post-site visit processing of all available information is where the Team can draft both short and long-term, mutually agreed upon recommendations for the Provider. There are several key steps that will facilitate this.

Team Debriefing

It is recommended that the QI Monitoring Team members meet within 24-48 hours after the completion of the monitoring visit to discuss the issues particular to the monitoring visit. By meeting directly after the onsite visit, Team members will have the greatest recall. Each Team member should share their experiences.

The Team Debriefing is an excellent opportunity for processing personal experiences, providing continuing education on the monitoring process, answering questions, and assessing the information gathered.

- **Impressions** – Team members share their thoughts and feelings about being part of a monitoring process, particularly if it is their first time.
- **Process the Visit** – Team discusses the successes and challenges they had in executing their monitoring tasks.
- **Analyzing the Findings** – Team reviews and clarifies various scores.
- **Final Report** – One Team member will be designated as the assigned author to write the final report. Timeframes are decided on when each Team member will deliver their information to the assigned author.
- **Technical Assistance** – There may be times that technical assistance might be planned ahead of the completion of the Final Report. In such cases, Team members will be assigned here for coordination of technical assistance and contact with the Provider.
- **Communication with the Provider** – Follow-up with the Provider occurs if any post-site visit documents are needed to complete the Final Report.

Final Report

This is a comprehensive written document that reflects the Monitoring Team's observations and assessments of the Provider's policies and practices regarding recovery-oriented principles and practices. While it must include objective findings of the Provider's policies and practices, it also will absolutely contain the Team's subjective appraisals of these items as well. Team members must be knowledgeable about recovery-oriented principles and be able to offer clear descriptions of evidence and their rationale on which their conclusions are based.

TOOLS

- ***Final Report Template***

- **Purpose** – To provide a clear and organized summary of findings of a Provider's recovery-oriented policies and principles, as well as to identify how they can be added and/or enhanced. It is intended to be written and viewed as a support to the Provider.

- **Structure** – A *Final Report Template* is available in APPENDIX D. It provides a structure for the Final Report and offers guidance in how to communicate the Team's findings and recommendations. It also provides suggested language that can be used to incorporate findings related to recovery-oriented strengths and areas for improvement.

- **Process** – The writing of an effective and timely Final Report is facilitated by a deliberate plan of action.
    - The Team Leader assigns a primary author or authors for the report.
    - Each Team member delivers their completed monitoring tools and scoring summaries, along with any other clearly documented information to the assigned author.
    - The assigned author(s) merge(s) all the collected information using the ***Final Report Template*** to create a Final Report draft. This is then disseminated the to all Team members for review.
    - Team members should check to see if their areas of review were appropriately referenced. They should also assess the overall report for clarity and offer any suggestions, revisions, and/or corrections as they see fit. It is recommended that each member return their copy with feedback to the assigned author within three (3) business days.
    - The assigned author(s) evaluate(s) and incorporates the Team's feedback to prepare the Final Report and disseminates it to all Team members once it is completed.
    - The Team meets to agree on the final draft of the report and all Team members sign the original of the Final Report.
    - Since the Recovery-Oriented QI Monitoring Final Report is incorporated into to a Managing Entity's Compliance Report, the Team Leader must coordinate with

the person in charge of the compliance report for guidance on how the QI Monitoring Report may be sent to the Provider.

- **Disclaimer and Limits** – It should be clearly noted in writing in the Final Report that *"the findings are based solely on the information that was available to the Team during the monitoring process."* Remember, even if the Team does not find evidence of a certain practice during their review that does not definitively mean that the Provider is not doing it at all.

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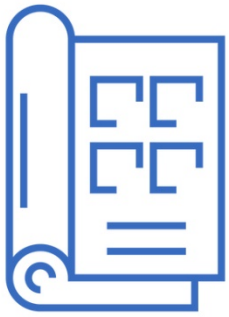


APPENDICES

APPENDIX A: CLINICAL RECORDS REVIEW

Scoring Instruments and Supporting Documents

- *Measuring Recovery-Oriented Principles and Practices Tool*
- *Where to Find Recovery-Oriented Scoring Information in the Clinical Record*
- *Scoring Tool for Recovery-Oriented Principles in the Clinical Record*
- *Excel Spreadsheet for Calculating Scores*

Clinical Record Reviews

Have on hand for reference -

1. Measuring Recovery-Oriented Principles and Practices Tool

2. Where to Find Recovery-Oriented Scoring Information in the Clinical Record

- Review each case file and score using the: ***Scoring Tool for Recovery-Oriented Principles in the Clinical Record.***
- Calculate scores and domain average scores.

- **Use one *Cumulative Scoring Tool for Recovery-Oriented Principles*** tool for each case file reviewed. Tabulate the average scores for each domain.
- Calculate the ***Overall Score of Averages for Clinical Record*** by averaging the scores on in that column using the hard copy tool or Excel Spreadsheet.

Using the Tools

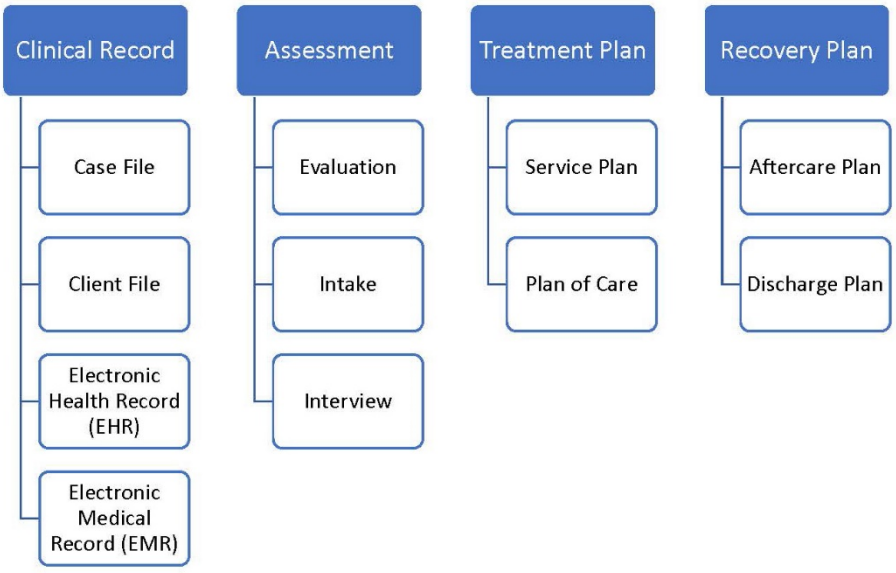
STEP 1. Become familiar with instruments.

Principles Evaluated in the Clinical Record

1. **Meeting Basic Needs**
2. **Comprehensive Services**
3. **Medication-Assisted Treatment**
4. **Strengths-Based Approach**
5. **Customization and Choice**
6. **Opportunity to Engage in Self-Determination**
7. **Network Supports/Community**

Before beginning the scoring process, it is important to become familiar with each principle being reviewed and where information can be found to effectively evaluate those principles. **The *Measuring Recovery-Oriented Principles and Practices Tool*** breaks down each principle to be reviewed and provides what kind of information should be present to fulfill that principle. It also identifies where that information may be found in both the clinical record and the interview with the person served. The companion guide ***Where to Find Recovery-Oriented Scoring Information in the Clinical Record*** is a quick reference sheet that further identifies where information for each principle may be found in the clinical record.

The ***Scoring Tool for Recovery-Oriented Principles in the Clinical Record*** introduces how to evaluate whether recovery-oriented principles and practices are being adhered to when performing a clinical record review. It outlines the elements under each principle that should be present and how that information would be presented in the clinical record. It breaks down each principle by identifying not only the specific details to look for but where that information should be located in the clinical record. It is important to note that the terms used for the documents and the clinical record may vary. The adjacent graphic identifies how these terms may differ.



If you are unsure what term is being used, ask a staff member at the facility or organization where you are performing the review.

STEP 2. Review each case file using the *Scoring Tool for Recovery-Oriented Principles in the Clinical Record.*

The Scoring Tool for Recovery-Oriented Principles in the Clinical Record is a complex document that outlines the domains for the review of clinical records. The review consists of the eight (8) domains (shown on the previous page) based on a 5-point Likert scale. A rubric is used to aid the scoring process by identifying what score should be provided based on how well each principle was established. In general, the numerical rating and item narrative follow this type of scale:

5 = Full and complete adherence to all components of the principle stated in the item narrative.

4 = A close approximation to the principle, but falls short on 1 or more of the necessary components.

3 = A significant departure from the principle, but nonetheless partially embodies the necessary components.

2 = Very little presence of the principle.

1 = Absence of the principle

Each recovery indicator has one or more items to rate. Rating descriptors are in the tool to designate the level of score that, in your critical opinion, is most fitting. **Some have five descriptors and some have three as in this example.**

	1	2	3	4	5
5a. Clinical Record Documentation identifies that the services are built upon a foundation of recovery principles that provide the individual with personal choice.	Clinical record documentation contains no mention of individual's choice in treatment.		Clinical record documentation refers to individual choice in treatment but does not make it the cornerstone of individual's treatment.		Clinical record documentation makes clear that individual choice is a fundamental principle guiding individual's treatment
	1	**2**	**3**	**4**	**5**
5b. Treatment Planning should reflect individualized goals, objectives, and interventions that become more customized as treatment progresses.	Treatment plans and subsequent updates have little to no variation. There is no indication in the treatment plan that it has been individualized for the person receiving services.	Treatment plans show minimal individualization with only a slight indication that it is individualized for the person being served.	Treatment plans show moderate degree of variation with some areas showing individualization and other areas not indicating any individualization for the person being served.	Treatment plans show high degree of variation but some areas still lack individualization for the person being served.	Treatment plans show substantial variation with each area indicating individualization for the person being served.

Despite these tools, determining what score to give in each domain will not always be clear cut. It is important that the reviewer use his or her best judgment when scoring. There is often a fear of being too subjective; however, there is always some level of subjectivity when these types of ratings are used. The key is to go into the review with the intent to be as objective as possible, remove emotional reactions from the equation, follow the guidance of the scoring tools, and apply the same type of judgment consistently across records reviewed.

How to Score

Review the clinical record and identify on the ***Scoring Tool for Recovery-Oriented Principles in the Clinical Record*** whether each element has been met.

3. Review each principle individually.
4. Follow the elements identified in the document *Measuring Recovery-Oriented Principles and Practices Tool*. This tool may be used as a checklist and place to take notes to help organize the information examined.
5. Review each document identified on the document ***Where to Find Recovery-Oriented Scoring Information in the Clinical Record*** and look for information that meets the recovery-oriented qualities for that principle.
6. Assign a score on the 5-point Likert scale based on the rubric provided for that principle.

You may discuss the use of psychotropic medication in the MAT section regardless of whether MAT is an appropriate treatment option. If MAT or psychotropic medication is not a viable option you may skip this section.

How to Calculate

Calculations will be derived for each of the eight (8) principles on each clinical record reviewed. Scoring is completed as simple additions and averages. For each section, there is a row for tabulating the score in each column where a score has been attributed. Add each column score to give the Total Score. The final score is an average of all scores for this section. The Scoring Tool provides the formula to arrive at the Average Score for each recovery indicator in each section.

	1	2	3	4	5
Column Score	_____	_____	_____	_____	_____
Domain Total and Average	Total Score:	_____ Total	Average Score:	_____ ÷ 2 = Total	_____ Average

1. Add the numbers in each vertical column for a total.

2. Take the calculated total and divide by the number of elements evaluated. Each principle will have either two (2) or three (3) elements. This will determine the average score for that particular individual.

If the MAT section is not applicable, then calculating the total score must be revised from dividing by seven (7) instead of eight (8) so as not to negatively skew the scoring results.

Each clinical record review should be paired with the interview with the person served. The scores can then be combined on the ***Cumulative Scoring Tool for Recovery-Oriented Principles*** to provide an average score for each clinical record reviewed.

An ***Excel Spreadsheet for Calculating Scores*** is also provided to help simplify the scoring calculations. This can be used to record and calculate the scores for both the clinical record review and the interview with the person served. The averages of each domain are entered on the spreadsheet which is programmed to calculate the overall average score for the clinical record and the interview with the person served – to arrive at an overall average score for both sets of reviews.

SEE APPENDIX C FOR CUMULATIVE SCORING INSTRUCTIONS.

APPENDIX B: INTERVIEWS with PERSONS IN RECOVERY

Scoring Instruments and Supporting Documents

- *Recovery Self-Assessment-R (RSA-R): Person in Recovery Version*
- *Scoring Tool for the Recovery Self-Assessment-R (RSA-R)*
- *Recovery-Oriented Principles for the Person in Recovery Interview*

Interviews with Persons in Recovery

- Administer the ***Recovery Self-Assessment-R (RSA-R): Person in Recovery Version*** and complete a person served interview with the persons served (people interviewed must match the clinical records reviewed).

- Complete the ***Scoring Tool for the Recovery Self-Assessment (RSA-R).***
- Calculate domain average scores.

- Use the same ***Cumulative Scoring for each Case File/Person in Recovery Interview*** tool for each person interviewed. Tabulate the average scores for each domain.
- Calculate the ***Overall Score of Averages for Individual Interview*** by averaging the scores on in that column using the hard copy tool or Excel Spreadsheet.

Using the Tools

STEP 1. Become familiar with the *RSA-R:* *Person in Recovery* *Survey* and the *Scoring Tool for the RSA-R.*

These tools identify whether recovery-oriented principles and practices are being adhered to through the eyes of the person served. The RSA-R consists of 32 statements divided into six (6) domains and is rated by the person served based on a 5-point Likert scale. The domains for the recovery self-assessment are similar, but distinctly different from, the principles used in scoring the clinical record.

Once you administer the RSA-R, the data will need to be compiled and analyzed. ***Please note that the questions will not be in the same order on the RSA-R as they are on the scoring tool***. The items are deliberately scrambled on the actual RSA-R to increase the validity of the survey. For this reason, the person RSA-R's results will need to be placed side-by-side with the Scoring Tool in order to properly score the assessment.

Domains Evaluated in in the Interview

1. **Life Goals**
2. **Involvement**
3. **Diversity of Treatment Options**
4. **Choice**
5. **Individually-Tailored Services**
6. **Inviting Factor**

STEP 2. Conduct an interview using the *RSA-R Person in Recovery Version.* Calculate the results of the survey with the *Scoring Tool for the RSA-R.*

Conduct the Interview

The interview should focus on the services that have been provided and the person's level of satisfaction with those services. The interview is typically conducted after the clinical record review and should consist of asking the person served to rate the 32 questions on *RSA-R.* The person served should be asked to rate each question on a scale from 1 to 5 with the highest score of 5 awarded where, in the opinion of the person using the service, the statement accurately reflects their best experience of the service. A score of one (1) would result if, in the judgement of the person, their experience of the statement had been not been met. The N/A (not applicable) option is to be recorded when the statement is not applicable or relevant to the service or the person using the service. The D/K (don't know) option should be used sparingly.

One issue that is commonly overlooked when persons are invited to comment on the services they receive is the power imbalance between the person served and the provider. Even when

the reviewer is independent of the provider, the person served may still feel uncomfortable about giving a critical appraisal for fear of losing the service or causing upset. Helping create a safe environment enables more honest sharing of experiences.

This scoring of each statement will be influenced by the person's subjective experience at both an interpersonal and relational level. It is known that staff dynamics such as attitudes, behavior, level of friendliness, warmth, and empathy are key factors in how people experience and rate services. These are important elements to keep in mind when conducting the interview and writing the final report.

When conducting the interview, the reviewer should follow these steps.

1. The reviewer should ensure, as much as possible, that the environment is relaxed and informal to make the person served more comfortable. The reviewer should remain open-minded and objective during the interview.

2. The reviewer should provide an introduction and a brief explanation as to why the interview is being conducted. This introduction will set the tone of the interview and may impact the person's willingness to participate. A sample introduction is:

   "*We are completing a review of this program to see how well recovery-oriented principles are being met. We invite you to share your personal perspective about the services you are receiving. Some questions may appear to be asking for the same information; however, we ask that you answer all the questions. Please identify if the question is truly not applicable or relevant to the services you have received."*

3. Answer any initial questions the person served may have about the process.

4. When ready to begin, provide the additional instructions which are adapted from the instructions on the RSA-R form.

   "*On a scale of 1 to 5, with one being strongly disagree and five being strongly agree, rate how accurately the following statements describe the activities, values, polices, and practices of this program."*

5. The statement or question should be read exactly as it is written. If the person does not understand the statement, it may be repeated with the same wording.

6. If there is any hesitation or the person appears confused, ask if additional clarification is needed. For example, the person may not understand what exactly is meant by 'culture' and this may need to be explained in the context of treatment. The reviewer may provide definitions or an example of what the question is referring to, but an answer should never be suggested.

7. Each statement will be considered and the highest score of 5 awarded where in the opinion of the person using the service the statement accurately reflects their

experience of the service. A score of one would result if, in the judgement of the person using the service, the intent of the statement had been not been met.

8. Arriving at a fair score between 1 and 5 is a matter of judgement based on reflection, discussion, and the application of reasoning regarding the quality and quantity of evidence.
9. Additional information that is provided by the person served that supports his or her answer on the 5-point scale should be documented and may be added to the final report.

How to Score

1. Complete the *RSA-R* with the person served via an interview.
2. Score the results of the survey with the *Scoring Tool for the Recovery Self-Assessment-R (RSA-R)*.
    a. The RSA-R item number in the left column refers to the corresponding number on the person served survey; this is where you can find the person's response to that particular question.
    b. In the right column the score that the person assigned to that question will be recorded.

How to Calculate

The following calculations will be repeated for each of the six (6) domains for each completed survey.

1. Add the numbers in the right item total column to calculate a domain score for that principle.
2. Divide the domain score by the number of questions under that specific principle.

Each interview should be paired with a clinical record review. The scores can then be combined on the *Cumulative Scoring Tool for Recovery-Oriented Principles* to provide an average score for each person served.

As noted in Appendix A, an ***Excel Spreadsheet for Calculating Scores*** is also provided to help simplify the scoring calculations. This can be used to record and calculate the scores for both the clinical record review and the interview with the person served. The averages of each domain are entered on the spreadsheet which is programmed to calculate the overall average score for the clinical record and the interview with the person served – to arrive at an overall average score for both sets of reviews.

APPENDIX C: CUMULATIVE SCORING

Scoring Instruments and Supporting Documents

- *Cumulative Scoring for each Clinical Record/Person in Recovery Interview*
- *Excel Spreadsheet for Calculating Scores*
- *Cumulative Scoring for All Case Files by Same Reviewer – Average Scores*

Clinical Records (Appendix A)

- **Use one *Cumulative Scoring Tool for Recovery-Oriented Principles* tool for** each clinical record **reviewed. Tabulate the average scores for each domain.**
- Calculate the ***Overall Score of Averages for Clinical Record*** by averaging the scores on in that column using the hard copy tool or Excel Spreadsheet.

RSA-R Interview with Person Served (Appendix B)

- Complete the ***Scoring Tool for the Recovery Self-Assessment (RSA-R), Person in Recovery***
- Calculate domain average scores using the hard copy tool or Excel Spreadsheet.

Step 1. Cumulative Scoring

- **Use one** *Cumulative Scoring for each Clinical Record/Person in Recovery Interview* **tool for clinical record reviewed and matched with the person interviewed. Tabulate the average scores for each domain.**
- Calculate the ***Overall Score of Averages for both the Clinical Record and Person in Recovery Interview*** by averaging the scores on in that column using the hard copy tool or Excel Spreadsheet. **Scoring is complete at this stage with a final score which is an average of the clinical record review and person in recovery interview.**

Step 2. Cumulative Scoring

- Use the ***Cumulative Scoring for All Case Files by Same Reviewer – Average Scores*** form. Enter the average score derived in Step 1 for clinical record/person in recovery.
- Calculate another average score derived from averaging the scores entered on this form **to arrive at a final average score for the organization.**

Using the Tools

Now that the scoring of the clinical records and the interviews is complete, it is time to use the Cumulative Scoring Tools to arrive at an overall score for organization.

- The first tool - ***Cumulative Scoring for each Clinical Record/Person in Recovery Interview –*** tabulates the average scores for the clinical record and interview for the person served who is matched to the clinical record. *A total average score is then derived for EACH of these matches.*

- The second tool - ***Cumulative Scoring for All Clinical Records/Person in Recovery by Same Reviewer – Average Scores –*** tabulates the average scores that were derived above for all clinical records/interviews conducted for the organization. Once again, these scores are averaged, resulting in an overall score for the organization in the area of adherence to recovery-oriented principles and practices and provision of MAT.

Step 1. Calculate the cumulative scores with the *Cumulative Scoring for each Clinical Record/Person in Recovery Interview*.

On this tool, record the results from the ***Scoring Tool for Recovery-Oriented Principles in the Clinical Record*** and the ***Scoring Tool for the Recovery Self-Assessment-R (RSA-R)*** in the indicated columns. Before proceeding, ensure that there is an average score for all domains on both scoring tools. These scoring tools were addressed in Appendix A and Appendix B.

Cumulative Scoring for Clinical Record/Person in Recovery Interview

Clinical Record #	Clinical Record Average Score		Individual Interview	Average Score		Average Score of Clinical Record and Individual Interview
1. Meeting Basic Needs		+	1. Life Goals		÷ 2 =	
2. Comprehensive Services		+	2. Involvement		÷ 2 =	
3. Medication Assisted Treatment (MAT)		+	3. Diversity of Treatment Options		÷ 2 =	
4. Strengths Based Approach		+	4. Choice		÷ 2 =	
5. Customization and Choice		+	5. Individually-Tailored Services		÷ 2 =	
6. Opportunity to Engage in Self-Determination		+	6. Inviting Factor		÷ 2 =	
7. Network Supports/ Community Integration					=	
8. Recovery Focus					=	
Reviewer's Name:	Overall Score of Averages for Clinical Record			Overall Score of Averages for Individual Interview Total		
If MAT is not applicable, divide by 7 instead of 8	÷ 8 (or 7) = Overall Average for Clinical Record	+		÷ 6 = Overall Averages for Individual Interview	÷ 2 =	Overall Average Score for All Domains

Step 2. Calculate the cumulative scores with the *Cumulative Scoring for All Case Files by Same Reviewer – Average Scores.*

The following calculations will be repeated for each person served who had both the clinical record review and the interview. It is important to identify whether the MAT principle was applicable for each person. If neither the use of MAT or psychotropic medications was appropriate for a particular person served, then this section should be skipped and the total will be divided by seven instead of eight to achieve an overall average score.

7. For individual files:
    a. Average the scores **in each row and column**.
    b. The bottom right cell in the table should have the **overall average score for that individual.**

8. For a set of files by a single reviewer:
    a. The reviewer should <u>enter the final overall average scores</u> for each individual that was reviewed and on the ***Cumulative Scoring for All Case Files by Same Reviewer – Average Scores***
    b. The overall average scores should then be averaged to identify how the agency did overall within the parameters of the total review process.

Cumulative Scoring for All Case Files by Same Reviewer – Average Scores

	Overall Average Score for Individual Record	Clinical Record #		
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
Reviewer's Name:	_____ Overall Average Score of All Records Reviewed	÷	_____ Total # of Records Reviewed	_____ Overall Average Score for All Records Reviewed by Individual Reviewer

APPENDIX D: FINAL REPORT PROTOCOLS

Supporting Documents

- *Recovery-Oriented QI Monitoring Site Visit Report Template*

Final Report

- Review initial findings at Debriefing.
- Submit all site visit documentation to the assigned author.
- Draft Final Report.
- Distribute *draft Final Report* to all Team members for comments, revisions, and accuracy; incorporate feedback and finalize report.
- Master copy of Final Report is signed by all Team members.
- Summarize findings and use key data to support where needed. Do not attempt to include all the raw data
- Include *objective* findings and *subjective* assessments that lead to recommendations.

Must have all of the following:

1.Measuring Recovery-Oriented Principles and Practices Tool

2. Scoring Tool for Recovery & MAT Elements in Clinical Record

3. Recovery Self-Assessment (RSA-R) – Person in Recovery version

4. RSA-R Scoring Tool for Person in Recovery version

5. Organizational Self-Assessment: Peer Support, Culture, and Leadership

6. Recovery Self-Assessment (RSA-R) – Provider version

7. Cumulative Scoring Tools

Structure

The Final Report from the Recovery-Oriented QI protocol will be incorporated into the overall State compliance report and therefore it does not need to repeat certain standard information that is already being covered. However, it should contain enough identifying information that connects it to the overall report, while also being able to stand on its own. This report can be divided into several sections including:

- Introduction and Overview
- Procedures
- Program Observations and Results
- Discussion and Conclusions
- Recommendations

Introduction and Overview

The introduction should provide an overview of the report with a brief synopsis of what will follow. Information that may be included are the dates of the visit, the location of the visit, the focus of the visit, and the purpose or objective of the visit. Other elements may also include why the site visit was conducted, the specific program being reviewed, the target population, provided services, and the project's overarching goals. One example of a statement of purpose is:

"*This site visit was designed to identify how (the Provider) incorporates recovery-oriented principles and practices and to use this baseline to help determine how these principles might be further integrated in the delivery of services."*

Background information that identifies the project history or purpose may be included in a very brief summary. If the project has an external funder, such as an organization or grant, consider including that information in the report for acknowledgement and transparency.

Procedures

This section should briefly identify the procedures that were used to complete the site visit. It may include pre- and post-visit information but will largely focus on the procedures that were used to complete the onsite visit. When possible, the protocols for site visits should be streamlined throughout the State for uniform procedures and more controlled results.

Identify how data was collected, such as the source of the data (interviews and clinical record reviews). This section can identify how many charts were reviewed, whether those charts were open or closed, how those charts were selected, and what programs the charts came from.

Similar processes of the site visit can be mentioned, such as how individuals were selected for interviews and which policies were reviewed.

The report should identify all elements of the site visit that the report is based upon.

- Policies, procedures and human resource information
- Clinical records reviews
- Persons-served interviews
- Staff interviews

This section is only to provide a high-level summary of the findings. If, however, a specific factor warrants special attention, it can be identified.

Program Observations and Results

Provide a summary of the findings from each area reviewed. Remember this is not a detailed play-by-play of what was discovered. In addition, there will be a Discussions and Conclusions section to follow for an overarching review of the findings and then a Recommendations section. Questions to consider to complete each section can be found at the end of this document.

Key Observation	Key Strengths and Opportunities
Identify key observation #	Identify related key strengths and opportunities • Add bullet points for additional information • Specific recommendations may also be listed here

This should be based on specific data that was gathered during the different phases of the site visit. While raw scores are not needed, an explanation of what the scores revealed can be discussed here. A summary of the findings can be included here and should include relevant information from the following areas:

Meeting Basic Needs	Basic needs includes access to safe housing, food, utilities, and medical care. Look at: • Do the assessments identify that the basic needs of persons served are met prior to treatment and what efforts are being made to ensure that any unmet needs are fulfilled during treatment and upon discharge?

	• Do treatment plans and progress notes reflect the steps that are being taken to ensure the needs of persons served are identified in assessments are being addressed?
Comprehensive Services	Look at: • What services are being provided to meet the treatment needs of persons served as evidenced by the treatment plan and progress notes? A variety of techniques, approaches, and support should be used to address current needs from the assessment, treatment plan, and progress notes. It should take a strengths-based approach with a recovery perspective. Cultural factors, such as attention to the values and beliefs of persons served should also be considered. Services should take a trauma-informed approach. Data from the RSA-R *Life Goals* and *Diversity of Treatment Options* section can be useful here.
Medication-Assisted Treatment (if applicable)	Look at: • Are those with substance use disorders being screened/assessed for appropriateness for MAT services? • Is there evidence that the benefits, risks, etc. of MAT were clearly presented? • If MAT services are provided, are they clearly outlined in treatment plan and progress notes? • Is there evidence that the pros and cons of each medication and possible alternative treatments? • If the Provider does not offer MAT services, is there evidence that referral options were provided?
Strengths-Based Approach	Look at: • Do interactions take a positive, strengths-based perspective? • Does clinical documentation reflect how existing strengths and resources can be used to overcome barriers and challenges? Data from the RSA-R *Inviting Factor* section can be useful here.
Customization and Choice	Look at: • Do the treatment, discharge and recovery plans show individualization and customization to the unique strengths, needs, and preferences of persons served?

	Data from the RSA-R *Choice* and *Individually-tailored Services* section can be useful here.
Opportunity to Engage in Self-Determination	Look at: • Are persons served being given a voice in developing their treatment, recovery and discharge plans including identifying goals, objectives, and providers after discharge? Data from the RSA-R *Involvement* section can be useful here.
Network Supports/ Community Integration	Look at: • Are support systems of persons served and available community resources both identified and, when possible, used in the treatment and recovery process? • Is there indication that traditional and non-traditional resources are being used, such as cultural healers or spiritual practices?
Recovery Focus	Look at: • Is there a focus on continued recovery that identifies recovery capital and demonstrate ongoing efforts to support recovery through elements such as employing a healthy lifestyles and support systems and self-care activities? • Does the discharge plan clearly identify how persons served will continue to receive services to support ongoing recovery? Data from the RSA-R *Inviting Factor* section can be useful here.
Persons Served Interviews	Look at: • Did persons served believe their needs were being met? • Did persons served feel involved in the treatment process? • Were persons served provided options for current treatment methods and aftercare providers? • Do persons served feel understood by staff?
Clinical Record Reviews	Look at: • Is the information consistently organized (i.e. follows an identified chart order)? • Is the documentation in the clinical records comprehensive? • Are specific elements present (i.e. strengths-based approach, MAT)? • Are clinical records paper, electronic, or a hybrid?

Discussions and Conclusions

This section synthesizes the information from the site visit into a cohesive summary. This section shifts from an objective perspective found in the results section to a more subjective perspective.

Strengths and opportunities identified in the site visit should be paired with aspirations of the organization and the State, and results. Using a strengths-based approach, with a focus on overarching recommendations for improvement and growth, will serve as the basis to highlight what the provider is doing well and how to build upon strengths instead of highlighting deficits. The end goal is that the organization embraces the recommendations for use in an action plan that can guide changes within the organization.

This section should identify how strategic actions can facilitate improvement in client outcomes, meet legal requirements, and assist the organization in meeting standards outlined by regulatory and oversight organizations. If the Department of Children and Families has agreed to provide any technical or other assistance, that information should be identified as well.

Recommendations

This section offers specific recommendations and the steps necessary for the Provider to either further enhance or add recovery-oriented policies and practices. Be sure to include both internal and external resources. Examples of recommendations might include:

- Add organizational policies.
- Strengthen existing organizational policies.
- Create internal committees or work groups focused on enhancing recovery-oriented practices.
- Develop internal training opportunities.
- Encourage utilization of existing external training opportunities
- incorporate Peer Specialists into an organization.
- Increase the effective utilization of Peer Specialists in an organization.
- Encourage organizational membership or participation in specified organizations, groups, coalitions, etc. that promote recovery-oriented practices.
- Create mechanisms for persons served to offer feedback, share experiences, and be represented in organizational decision and policy-making, through the use of surveys, speaking opportunities, advisory boards, etc.
- Identify the types of Technical Assistance that could be provided by the Team/Department or Children and Families.

APPENDIX E: FINAL REPORT TEMPLATE

Recovery-Oriented Quality Improvement Monitoring: Final Report

Organization Name:

Date(s) of Site Visit:

Introduction and Overview

- Purpose
- Job description reviews
- Facility tour observations

Procedures

- How the data was collected
- Types of data collected

Program Observations and Results

- Include all areas reviewed
    - Policies, procedures and human resources documents
    - Clinical records review
    - Persons-served interviews
    - Staff interviews

Meeting Basic Needs	
Observations:	**Strengths:**
	Opportunities:

Comprehensive Services	
Observations:	**Strengths:**
	Opportunities:

Medication Assisted Treatment (if applicable)	
Observations:	**Strengths:**
	Opportunities:

Strengths-Based Approach	
Observations:	**Strengths:**
	Opportunities:

Customization and Choice	
Observations:	**Strengths:**
	Opportunities:

Opportunity to Engage in Self-Determination	
Observations:	**Strengths:**
	Opportunities:

Network Supports/Community Integration	
Observations:	**Strengths:**
	Opportunities:

Recovery Focus	
Observations:	**Strengths:**
	Opportunities:

Discussion and Conclusions

- Summarize potential Best Practices.
- Discuss integration of internal and external resources.
- Identify the potential benefits of continuing existing desired practices along with implementing recommendations.
- Identify any Technical Assistance offered by the Florida Department of Children and Families.

Recommendations

- Identify specific recommendations for the Provider.
- Identify the strategic elements in making those changes.
- Identify relevant internal and external resources.