Recovery-Oriented Systems & Services

Where are we now, Where are we going?

Presented at

35th Annual ICADD Conference

Embracing A New Dawn in Behavioral Health

May 16, 2019

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**Executive Director, John Maxwell Team**

Learning Objectives
By the end of the Keynote & Workshop participants will:

- Create a foundational framework around Purpose, Collaboration; and A system of care that builds on strengths, opportunities, aspirations and results.

- Understand ROSC; its goals, principles and values.

- Understand the distinction between disease management and recovery management.

- Learn 5 predictions about addiction recovery support in the United States

- Identify 11 prescriptive actions that addiction professionals can use to elicit hope in the face of addiction-fueled despair ~White & Collins

- Learn about local and national Outcomes & Process Evaluation tools and data.

- **Explore implications of how treatment looks within a recovery-oriented system**

- **Learn the 3 Approaches to ROSC Transformation**

- **Be exposed to and use strength-based approaches and language while experiencing a variety of Recovery Management activities, tasks and tools that they can adopt and transfer to others in their organizations and communities.**

- **Begin thinking through potential application and strategies for next steps**

Sometimes we overestimate the event, and underestimate the Process!

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KNOWING YOUR WHY

Why?

How?
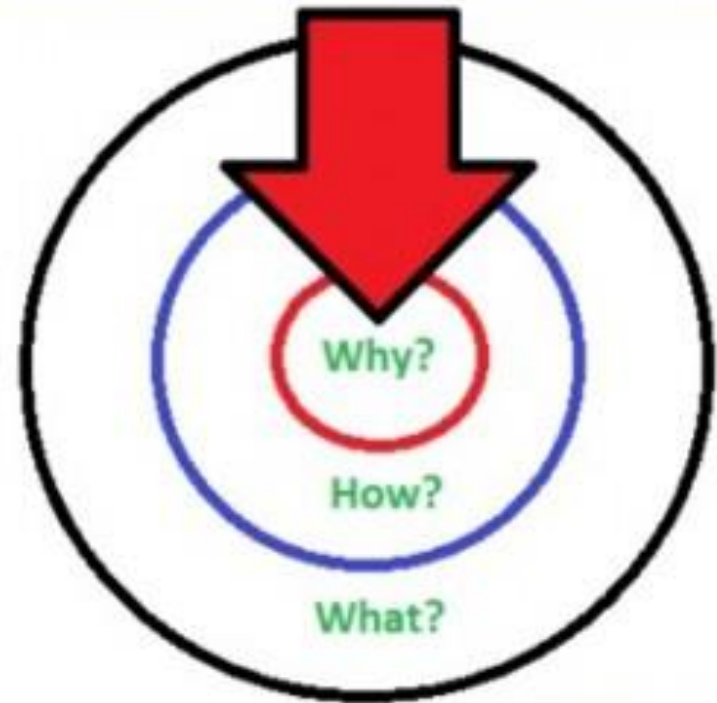
What?

Your Expectations and Roles

What do you see as your role in a Recovery Oriented System of Care?

What do you anticipate the benefits will be for your system of care after **integrating ROSC in your facility**?

Unmet Need

Failure to Attract

1. Among adults reporting a behavioral health condition, more than half report onset in childhood or adolescence

2. Average delays in help seeking for mental health and SUD challenges is more than a decade
(National Comorbidity Study)

3. Less than 10% of those who need SUD treatment seek treatment

Why ROSC?

Why ROSC?

Low Pre-Treatment Initiation Rates

Limited Retention/Engagement

Lack of Continuing Support : For SUD, only 1 in 5 receive post-discharge planning

SUD recovery outcomes: more than 50% resume using within 1 year and most within 90 days following discharge

High Recidivism rates

Similar Cross System Challenges

High Recidivism in Criminal Justice

"Within three years of release, about two-thirds (67.8 percent) of released prisoners were rearrested.

Within five years of release, about three-quarters (76.6 percent) of released prisoners were rearrested.

Of those prisoners who were rearrested, more than half (56.7 percent) were arrested by the end of the first year."

Multiple and complex needs require attention for successful re-integration

National Institute of Justice, June 17, 2014

Bureau of Justice Statistics Special Report, April 2014

Similar Cross System Challenges

Child Welfare

Families have complex needs, but CW agencies do not have control over all of the services needed

"Often, mismatch between services offered & what families actually need to resolve their difficulties."

Increasing caseloads

Community Challenges

Countless families are often devastated by the disease of addiction

People with MH conditions are often isolated and not living life to the fullest

People don't know where to turn for help for loved ones or how to get loved ones into treatment

High stigma keeps people isolated and suffering alone

Community members who want to help don't know how to help

We often only see the disease, we never see recovery. Therefore families and individuals don't have hope that recovery is a real reality for them.

Intersecting Challenges: Analysis of the Current State

Disjointed, fragmented systems and approaches can't provide the holistic array of services and supports that are needed

Reactive systems: Majority of resources focused on those with the most severe, chronic illness and challenges with limited focus on keeping people well or addressing the needs of those who are vulnerable

Deficit-focused approaches, address the urgent need but don't address the root issues, the associated challenges, and are not solution focused

Addiction Shares Many Characteristics with other Chronic Medical Disorders

Addiction/Chronic Illness	Compliance Rate	Relapse Rate
Alcohol	30-50	50
Opioid	30-50	40
Cocaine	30-50	45
Nicotine	30-50	70
Insulin Dependent Diabetes		
Medication	<50	30-50
Diet and Foot Care	<50	30-50
Hypertension		
Medication	<30	50-60
Diet	<30	50-60
Asthma		
Medication	<30	60-80

Slide Acknowledgment: William White. Data Source: O'Brien CP, McLellan AT. Myths about the Treatment of Addiction (1996). The Lancet, Volume 347(8996), 237-240.

What is ROSC?

ROSC is not:

- A Model
- Primarily focused on the integration of recovery support services
- Dependent on new dollars for development
- A New initiative
- A Group of providers that increase their collaboration to improve coordination
- An Infusion of evidence-based practices
- An organizational entity
- A closed network of services and supports

ROSC is:
- Value-driven APRROACH to structuring behavioral health systems and a network of services and supports
- Framework to guide systems transformation

Paradigm for High Performing Systems and Organizations Is Expanding

FROM: **How can we get populations healthy?** How do we best protect children? How do we transition CJ involved people into communities, reduce recidivism, and ensure community safety?

TO: **How do we help people to get well and stay well?** How do we not only prevent abuse, but also promote health and wellness? How do we help children, families and all individuals to thrive, develop meaningful lives, and sustain their wellness?

How do we make this shift?

ROSC as a Conceptual Framework & Road Map

SOCIAL SUPPORT

Trauma-informed Services

Peer Support

Justice Systems (Adult & Juvenile)

Housing Improvements

Recovery Community Organizations

Prevention

Treatment and Medication Support

Physical Health

Hospitals

Managed Care

Life skills training

Government

Veterans Administration

Healthy Relationships

Employment Opportunities

Child Welfare

AA and NA

Family Education & Support
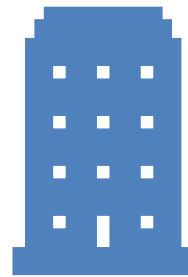
Recovery Community

Faith-based Support

NAMI

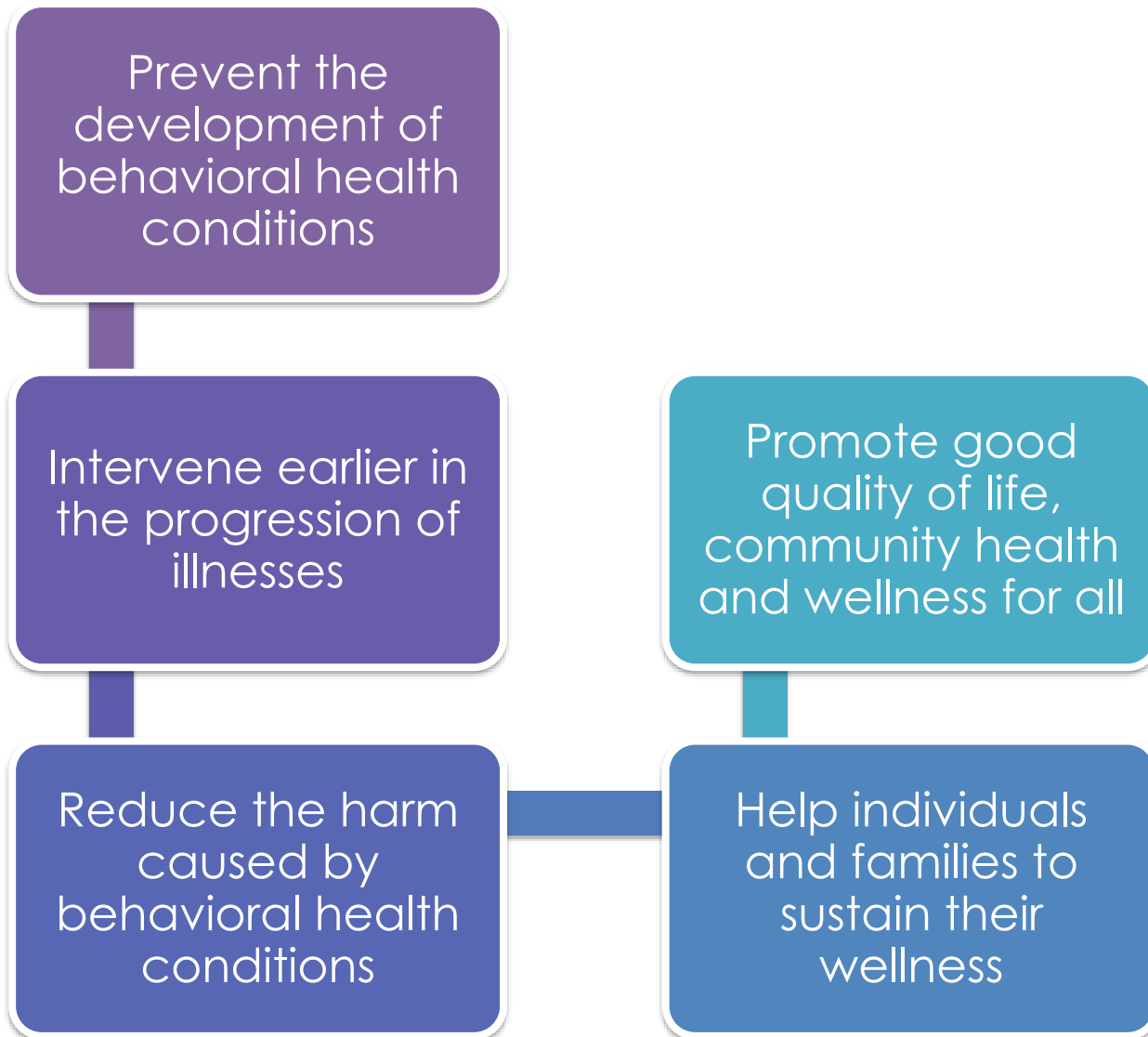SCHOOLS, ACADEMIC INSTITUTIONS, RESEARCH

7 Building blocks of a ROSC

1. Aligning Treatment with a Recovery-Oriented System of Care

2. Fully Integrating Peer and Other Recovery Support Services

3. Supporting the Development of a Mobilized Activated Recovery Community

4. Integrating recovery-oriented Performance Improvement and Evaluation

5. Developing a shared vision and strengthening cross-system collaborations

6. Focus on Prevention and Early Intervention through Promotion of Population and Community Health

7. Fiscal Policy, Regulatory and Administrative Alignment

PRIMARY GOALS OF A ROSC

Prevent the development of behavioral health conditions

Intervene earlier in the progression of illnesses

Reduce the harm caused by behavioral health conditions

Promote good quality of life, community health and wellness for all

Help individuals and families to sustain their wellness

Health is a state of COMPLETE physical, mental and social well-being and not merely the absence of disease or infirmity.
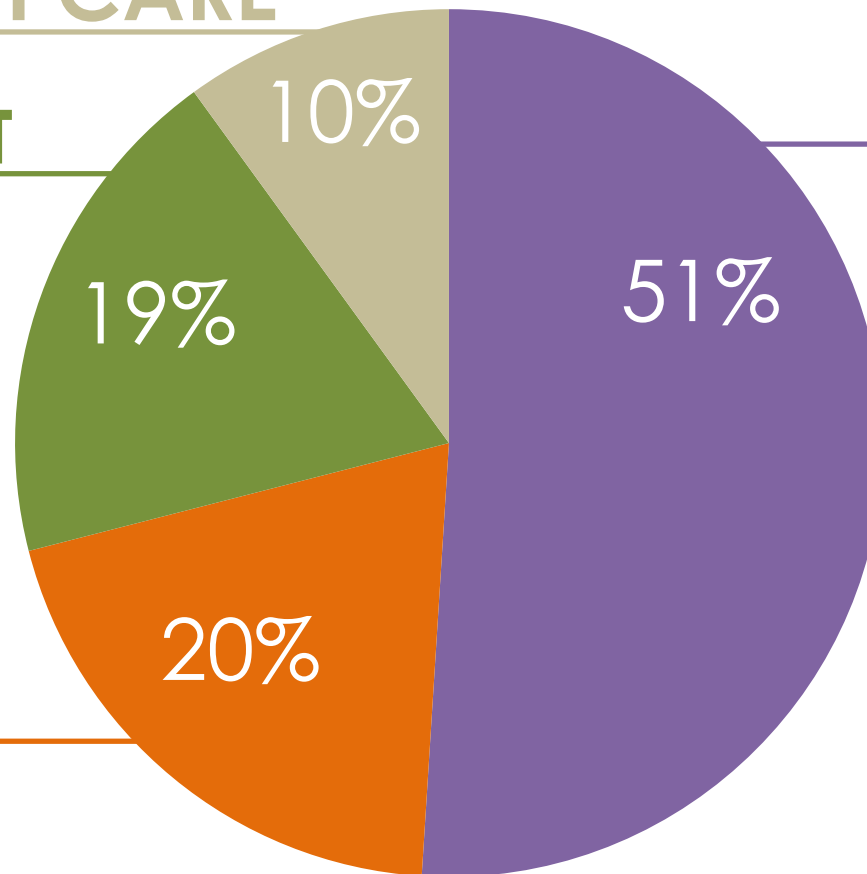
World Health Organization
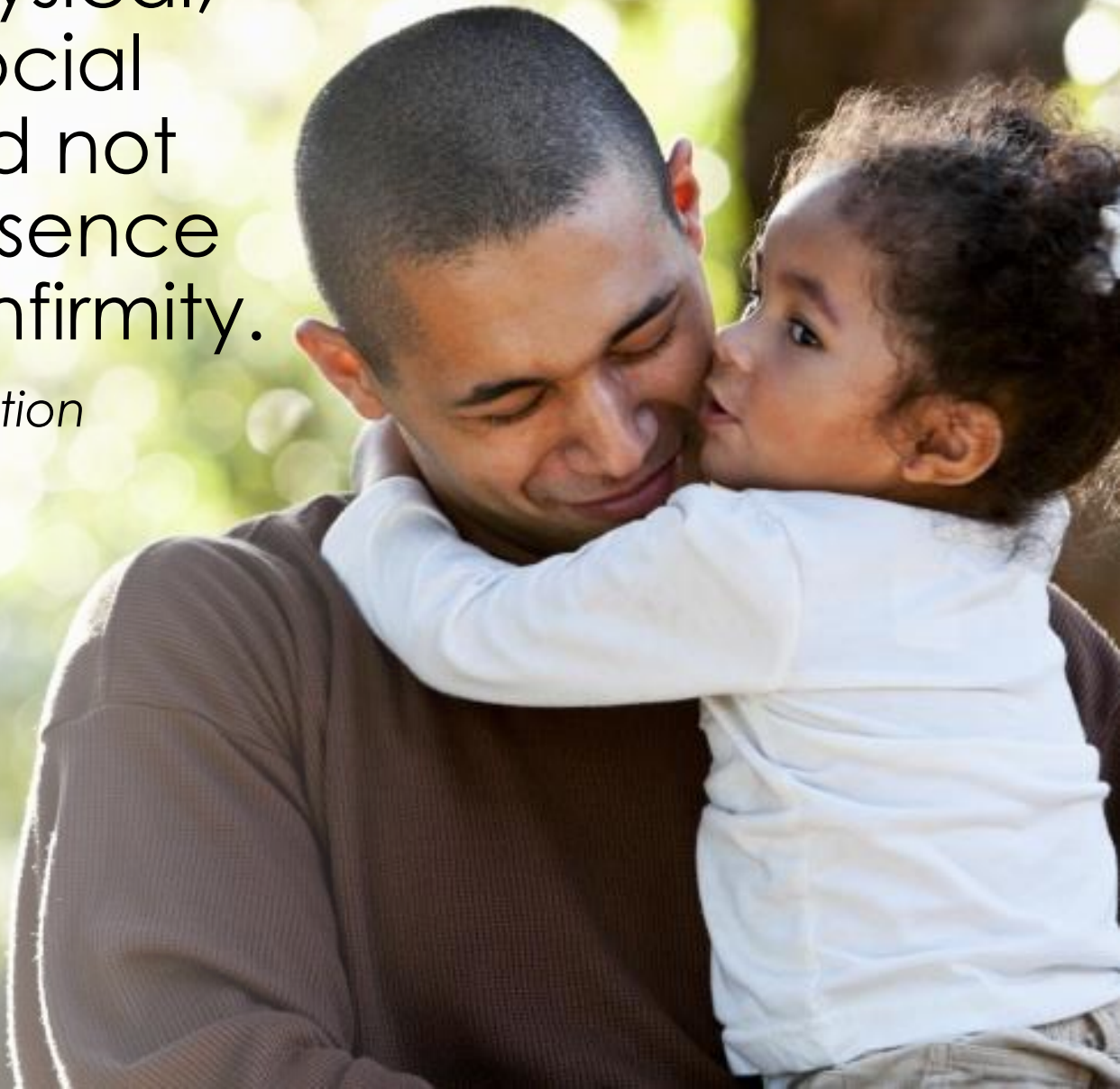
Factors that Influence Health Status

HEALTH CARE

ENVIRONMENT
Living Environment
Safety
Housing
SES/Employment

HUMAN BIOLOGY

10%

19%

20%

51%

LIFESTYLE
Smoking
Obesity
Stress/Coping
Nutrition
Blood Pressure
Social Support

Arthur C. Evans Jr.

Lifestyle and Environmental Factors

Account for 70% OF HEALTHCARE OUTCOMES

Values and Guiding Principles
A Snapshot

Person-Centered	**Holistic Approaches**	**Family and other Ally Involvement**	**Individualized and Comprehensive**
Anchored in the Community	**Continuity of Care**	**Partnership-Consultant Relationships**	**Strengths-based**
	Culturally Responsive	**Commitment to Peer Recovery Support Services**	**Inclusion of those with lived experience and their families**

Person-centered recovery planning Balances Priorities

Important *TO* the Person
PERSONAL PERSPECTIVE

- Meaningful relationships
- A home/place of my own
- Valued roles/purpose
- Independence/ Self-determination
  - Cultural/personal preferences may impact
- Faith/spirituality
- A job/career
- Family expectations

Important *FOR* the Person
PROFESSIONAL PERSPECTIVE

- Basic health and safety
  - Reduction of clinical symptoms
  - Maslow's basic needs
  - Harm reduction
  - Management of risk issues
- Legal obligations and mandates
- Community Safety

Benefits of a Person Centered Approach?
Example: Western New York Care Coordination Program
Janice Tondora, Yale Program on Recovery and Community Health

OUTCOMES ACHIEVED

- 68% Increase in competitive employment
- 43% decrease in ER visits
- 44% decrease in inpatient days
- 56% decrease in self-harm
- 51% decrease in harm to others
- 11% decrease in arrests

Tondora, Janis; Miller, Rebecca; Davidson Larry. The Top Ten Concerns about Person-Centered Care Planning in Mental Health Systems. **International Journal of Person Centered Medicine**, [S.l.], v. 2, n. 3, p. 410-420, sep. 2012. ISSN 2043 7749.

The primary focus is adding peer staff to a service setting.

Small tweaks are all that is necessary to make services more recovery-oriented.

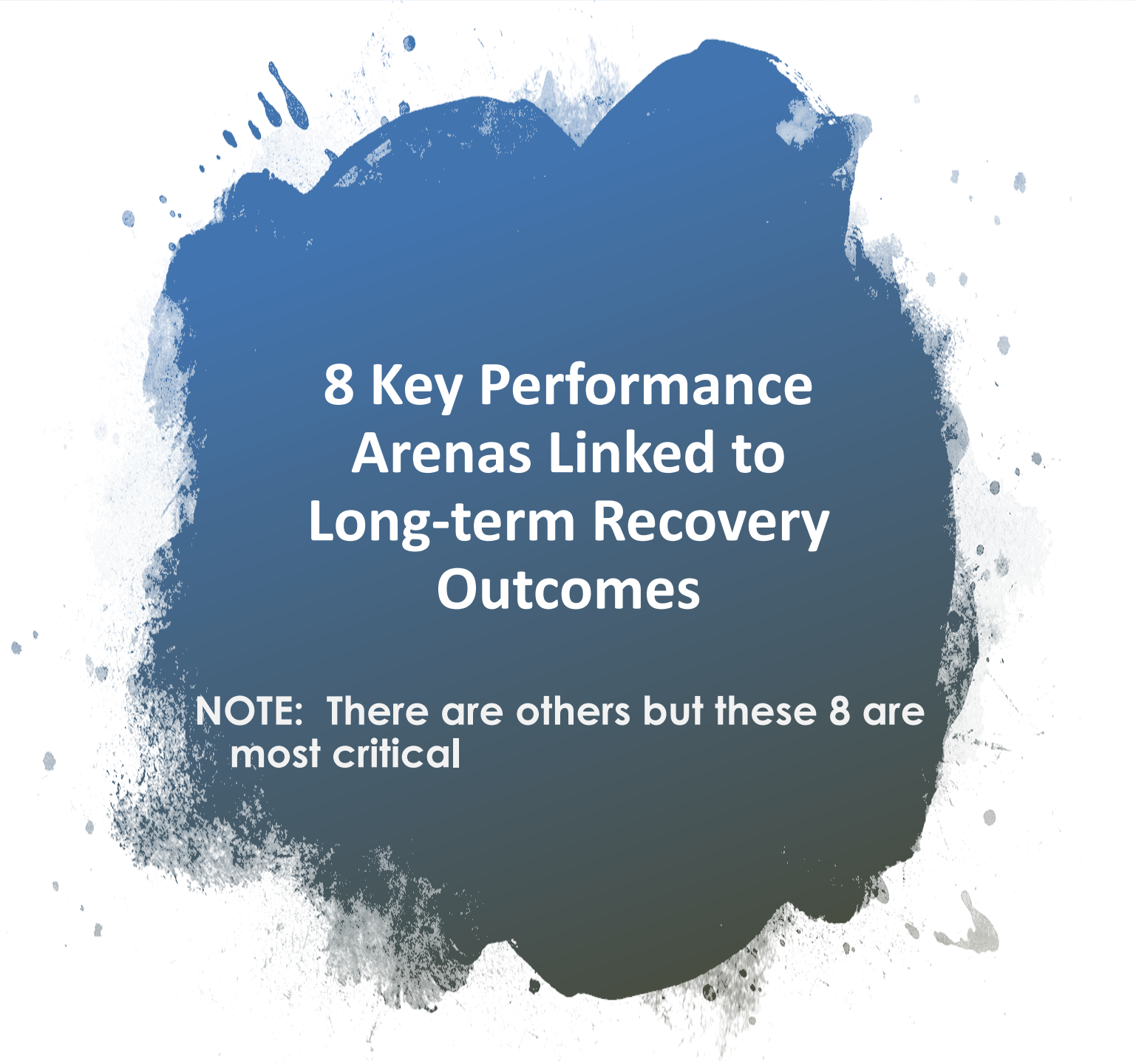It's all about "feel good fluff."

Common Myths About ROSC

Conceptual & Language Clarity

"**Recovery Management" (RM)** is a philosophical framework for organizing addiction treatment and recovery support services across the stages of pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality of life enhancement for individuals and families affected by severe substance use disorders.

Recovery Management & Stages of Recovery

1. Pre-recovery identification and engagement (recovery priming)

2. <u>Recovery initiation and stabilization</u>

3. Transition to successful recovery maintenance

4. Enhancement of quality of personal/family life in long-term recovery

8 Key Performance Arenas Linked to Long-term Recovery Outcomes

NOTE: There are others but these 8 are most critical

8 Key Performance Arenas Linked to Long-term Recovery Outcomes

- Attraction, access & early engagement

- Screening, assessment & placement

- Composition of the service team

- Service relationship

- Service dose, scope & quality

- Locus of service delivery

- Assertive linkage to communities of recovery

- Post-treatment monitoring, support and early re-intervention

White, W. (2008). *Recovery management and recovery-oriented systems of care.* Chicago: Great Lakes Addiction Technology Transfer Center, Northeast Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services

1. Attraction, Access & Early Engagement

Acute Care (AC) Limitations

- 10% & 25% data; late stage and under coercion; waiting list drop-out data; attrition data (more than 50% will not complete)

Recovery Management (RM) Directions

- Assertive community education & outreach
- Assertive waiting list management
- Lowered threshold of engagement; rethinking motivation; institutional outreach
- Changes in administrative discharge policies

2. Screening, Assessment & Placement

AC ASSESSMENT IS CATEGORICAL, PATHOLOGY-FOCUSED, PROFESSIONALLY-DRIVEN, AN INTAKE FUNCTION & FOCUSED ON INDIVIDUAL; PLACEMENT BASED ON PROBLEM SEVERITY.

RM ASSESSMENT IS GLOBAL, STRENGTHS-BASED, CLIENT FOCUSED (RAPID TRANSITION TO RECOVERY PLANS), CONTINUAL AND ENCOMPASSES THE INDIVIDUAL, FAMILY AND RECOVERY ENVIRONMENT; RECOVERY CAPITAL FACTORED INTO PLACEMENT DECISIONS.

3. Composition of the Service Team

AC model uses disease rhetoric but few medical personnel; recovery rhetoric but decreasing involvement of recovering people.

RM expands roles of medical (including primary care physicians) and other allied professionals, recovering people (P-BRSS) and culturally indigenous healers. Also emphasizes reinvestment in volunteer and alumni programs.

4. Service relationship

AC: DOMINATOR MODEL; EMPHASIS ON PROFESSIONAL AUTHORITY; GREAT POWER DISCREPANCY; ROLE OF CLIENT IS ONE OF COMPLIANCE.

RM: SUSTAINED RECOVERY PARTNERSHIP (LONG-TERM CONSULTATION) MODEL; EMPHASIS ON PROLONGED CONTINUITY OF CONTACT; CLIENT AS CO-LEADER; PHILOSOPHY OF CHOICE; GREATER USE OF PERSONAL/PROFESSIONAL SELF; CONTRASTING ETHICAL GUIDELINES.

5. Service Dose, Scope & Quality

AC model has become ever briefer, narrower via reimbursable services & continues to incorporate methods lacking scientific support.

RM model emphasis on importance of dose (NIDA principles—90 days), role of ancillary services and weeding out practices that are not linked to recovery outcomes or that may produce inadvertent injury.

6. Locus of Service Delivery

AC model locus is the institution: How do we get the individual into treatment—get them from their world to our world?

RM model emphasizes the ecology of long-term recovery: "How do we nest recovery in the natural environment of this individual or create an alternative recovery-conducive environment?"

* Healing forest metaphor (Coyhis)

* Concept of "community recovery"

7. Assertive linkage to communities of recovery

AC model: Passive linkage, low affiliation and high early attrition, single pathway model of recovery

RM model: Assertive linkage, multiple pathway model of recovery, linkage beyond recovery mutual aid groups; active relationship with local service committees, involved in recovery community resource development

AC Model: "Aftercare" as an Afterthought

Post-discharge continuing care can enhance recovery outcomes (Johnson & Herringer, 1993; Godley, et al, 2001; Dennis, et al, 2003).

But only 1 in 5 (McKay, 2001) to 1 in 10 (OAS, SAMHSA, 2005) adult clients receive such care (McKay, 2001) and only 36% of adolescents receive <u>any</u> continuing care (Godley,et al, 2001)

RM Model: Assertive Approaches to Continuing Care

- Post-treatment monitoring & support (recovery checkups)

- Stage-appropriate recovery education & peer support

- Assertive/continued linkage to recovery resources

- Early re-intervention & re-linkage to treatment and recovery support peers and resources

- Recovery community building

The pain of addiction-related consequences serves as a catalyst of recovery only in the presence of hope" ~William White

11 prescriptive actions to elicit hope in the face of addiction-fueled despair.

Practice a Ministry of Presence

Capitalize on Crisis

Normalize Ambivalence

Express Confidence in Their Capacity to Recover

Offer Living Proof of Recovery

Acknowledge the Varieties of Recovery Experience

Share Iconic Stories

Facilitate Story Reconstruction and Storytelling

Provide Exposure to the Culture of Recovery

Provide systems navigation

Convey the promises of recovery

Community Integration

"The central concern shifts from *How do we get the client into treatment?*

to

How do we nest the process of recovery within the person's natural environment."
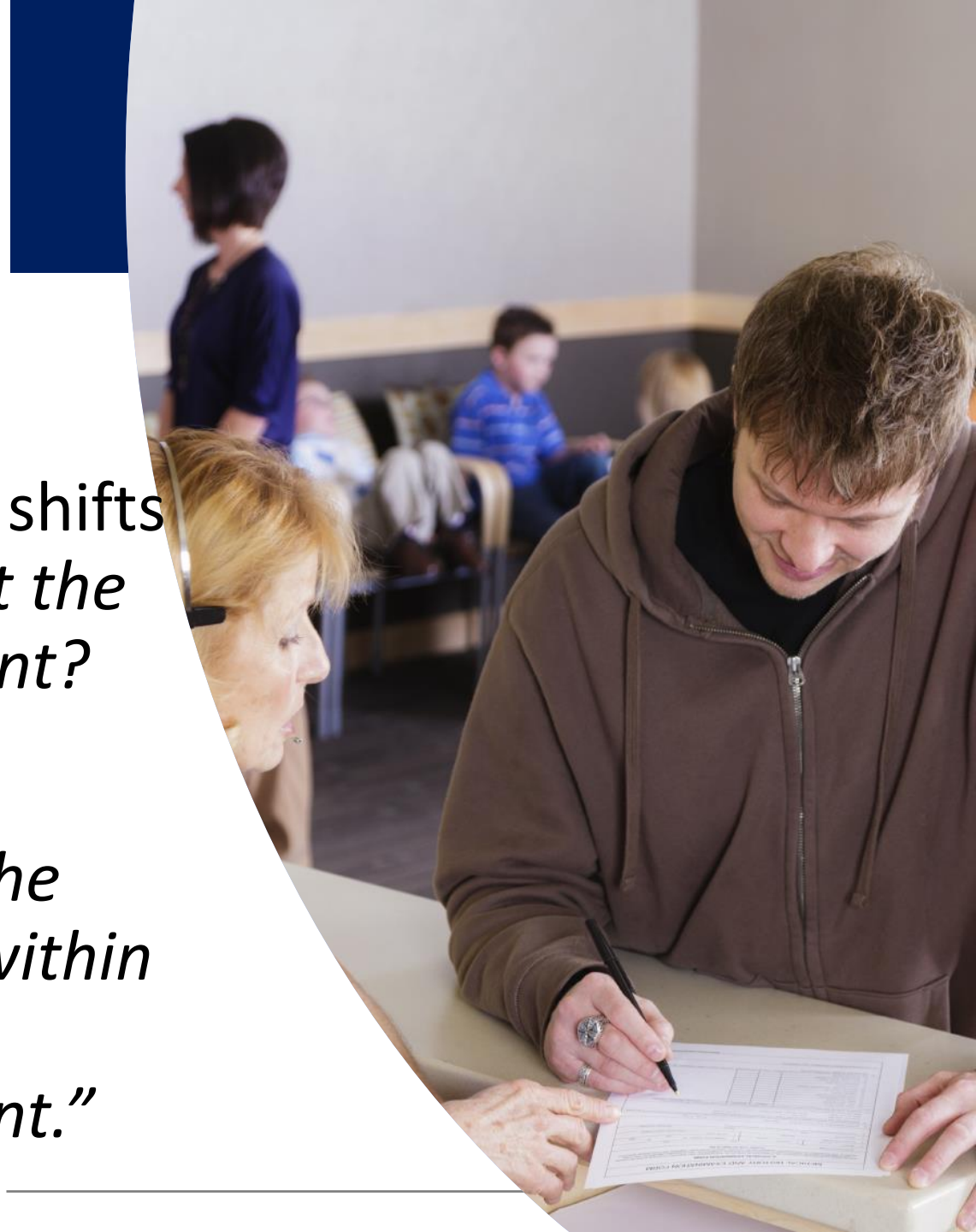
Integrating Peer Recovery Support Services

Function of Peer Specialist

Role model of recovery and living well with a diagnosis

Assist in developing strengths-based individual goals, including Recovery Capital

Serve as a mentor and advocate

Develop community support

Educate on ways to maintain wellness and recovery

Education on navigation of community services and recovery

Potential Roles of Peer

Some Examples Include:

- Conducting assertive outreach

- Facilitating life skills and other peer support groups

- Participating in all phases of person-centered planning processes including assessment and treatment/recovery planning

- Focusing on recovery capital assessment at the individual, family and community level

- Assisting people in identifying recovery goals and strategies to attain their goals

- Orienting people to the variety of resources available in the community and assertively connecting them to those resources

Potential Roles of Peer

- Peers in local Emergency Rooms, Shelters, Courts

- Peers in Primary Care Settings

- Peer staffing engagement or recovery centers within agency or community

- Pre-treatment engagement groups in jails

- Helping people bridge multiple levels of care and easing their transition from each level to the next

- Conducting periodic checkups after treatment

- Participation in court diversion programs

- Assertively connecting people to relevant resources in their community

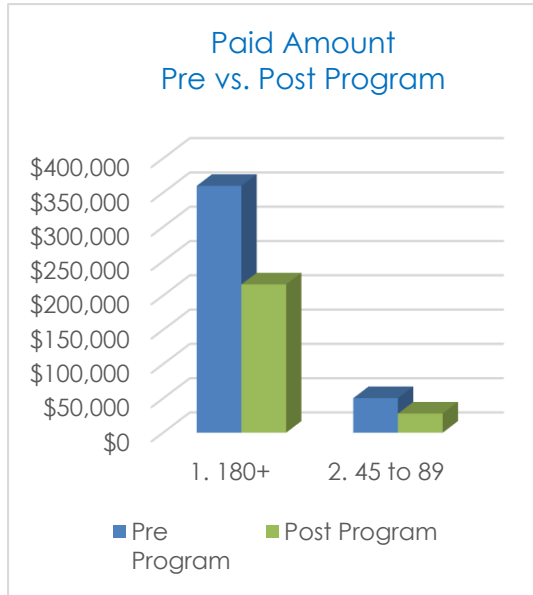- Peers participating in the development of continuing care plans

Philly Recovery Walk 2009: 5,800

2016: 30,000

Outcomes for Cohort of Members with a *Minimum of Two Inpatient Admissions in 30 days upon Enrollment in Magellan Complete Care's Internal Peer Support Program
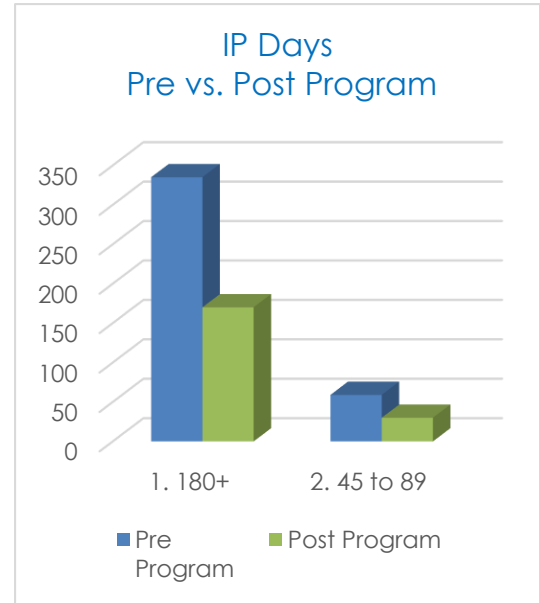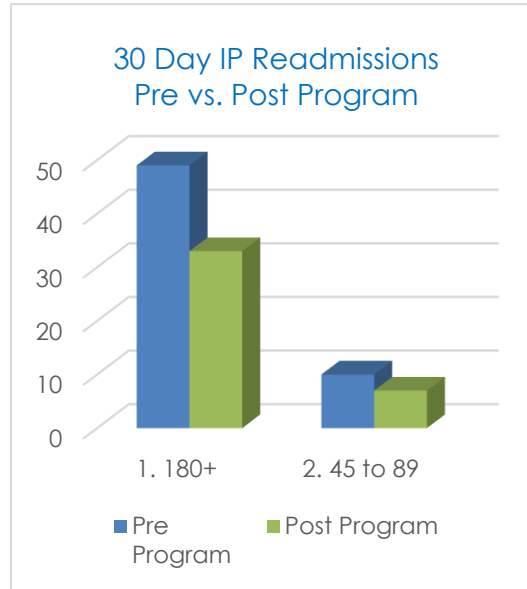
- **After 89 days in the peer support program, 44% reduction in paid amount, 30% decrease in inpatient readmissions, and 49% decrease in inpatient days.**

- **After 180 days in the peer support program, 40% reduction in paid amount, 33% decrease in inpatient readmissions, and 49% decrease in inpatient days.**

Benefits: **Examples from Connecticut**

- 24% decrease in expenses

- 46% increase in # of people served statewide

- 40% increase in outpatient care

- 25% decrease in annual cost per client

- 14% lower costs with recovery supports

Increased Employment and Housing Status

Texas DSHS RSS Project:

Housing Increased over time:

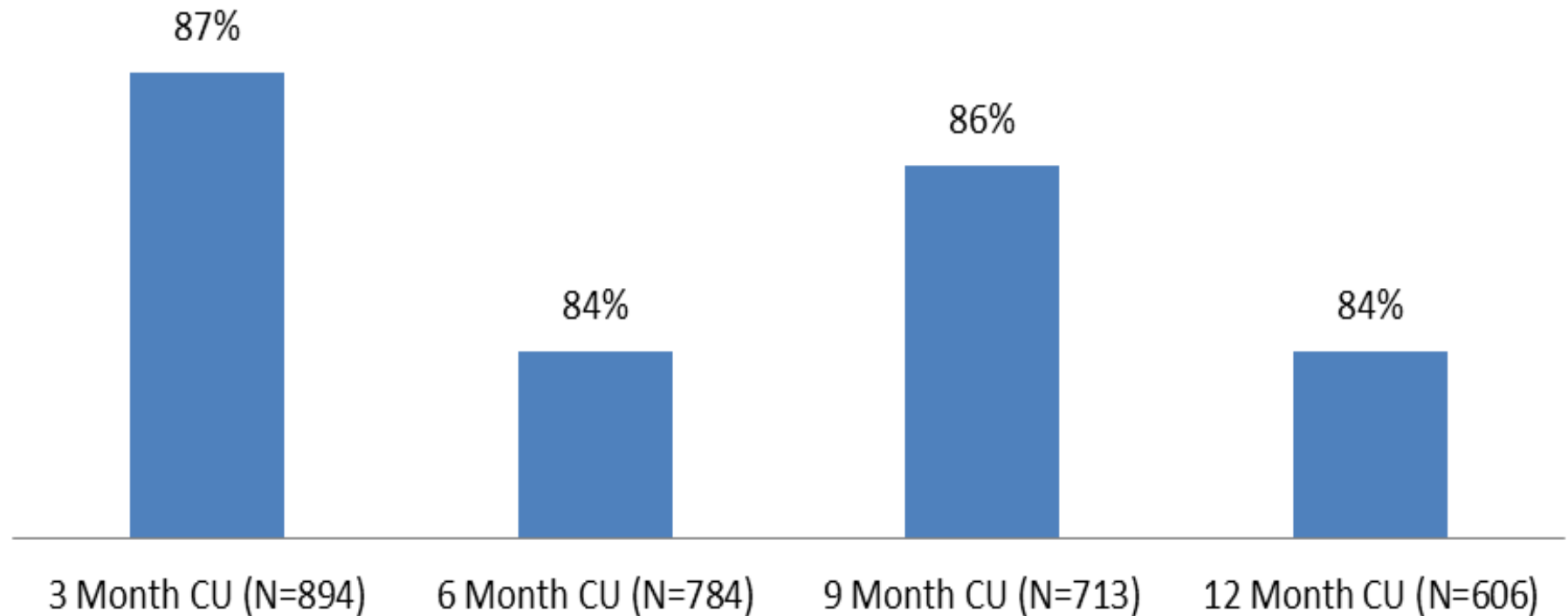- Enrollment (68%) to 12-month check-up (89%).

Employment increased over time:

- Full-Time (Enrollment=13%; 12-Month=42%)

Texas DSHS RSS Project – Philander Moore,
Evaluation by University of Texas, Mangrum, et al. 2016

Percentage of RC Participants Abstinent or
Reduced Substance Use at Check-Ups
RED-ROC Data May 2014 - August 2015

- 3 Month CU (N=894): 87%
- 6 Month CU (N=784): 84%
- 9 Month CU (N=713): 86%
- 12 Month CU (N=606): 84%

Estimated Healthcare Cost Savings of
Long-Term Recovery Coaching Participants
(RED-ROC Data May 2014 - August 2015)
N=648

$2,718,442

76% Reduction in Health Care Costs
Between Enrollment and 12-Months

Texas DSHS RSS Healthcare Service Utilization
Cost Savings

$866,069

$763,736

$682,203

$653,512

Enrollment   3 Month   6 Month   9 month   12 month

Benefits of Peer Support in Child Welfare

"In Contra Costa, CA 62% of children whose parents were served by Parent Partners reunited with their parents within 18 months of removal, compared to 37 percent of children whose parents were not served."

National Technical Assistance and Evaluation Center for Systems of Care, DHHS, 2010, Pg. 30

Benefits of Peer Support in CJ

From Recidivism to Recovery

Individuals receiving peer support in 30 Pennsylvania county jails demonstrated a 3 yr recidivism rate of 24% compared to 46% of those without peer support.

If there is no transformation inside of us, all the structural change in the world will have no impact on our institutions.

Peter Block

Recovery-oriented approaches are no longer dismissed as a passing trend but have withstood the test of time. In fact, grounded in the conviction that recovery is possible, ROSCs are proliferating nationally and globally. ~Dr. Ijeoma Achara

ROSC & Recovery Management Part II

Subsequent to the Morning Keynote

Implications for Treatment Services

THE HEALING FOREST

The Community Is The Treatment Center

~Andy Chelsea, Shuswap – Tribal Chief at Alkali Lake
~Taken from Don Coyhis & William White

Assertive Outreach, Engagement and Early Intervention

**Meeting People
Where They Are**

- No Administrative Discharges for Set-Backs

- No "come back
  when you are clean"

- Looking for Opportunities to assertively connect people to resources

Strategies to Promote: Assertive Outreach and Engagement

Pre-treatment Peer Support Groups

Going into jails and prisons before release

Offer peer mentors as soon as contact is initiated

For urban settings, develop a welcome/recovery support center

Focus on care coordination

Tele-health particularly in rural settings

Build strong linkages between levels of care

Use charismatic & engaging staff in reception areas

Connect with people before initial appointments

**Screening and early intervention in health facilities**

Establish relationships with natural supports to promote early identification

Assertive Outreach, Engagement and Early Intervention

> "My clients don't hit bottom; they live on the bottom. If we wait for them to hit bottom, they will die.

> **The obstacle to their engagement in treatment is not an absence of pain; it is an absence of hope.**"

Outreach Worker
(quoted in *White, Woll, and Webber* 2003)
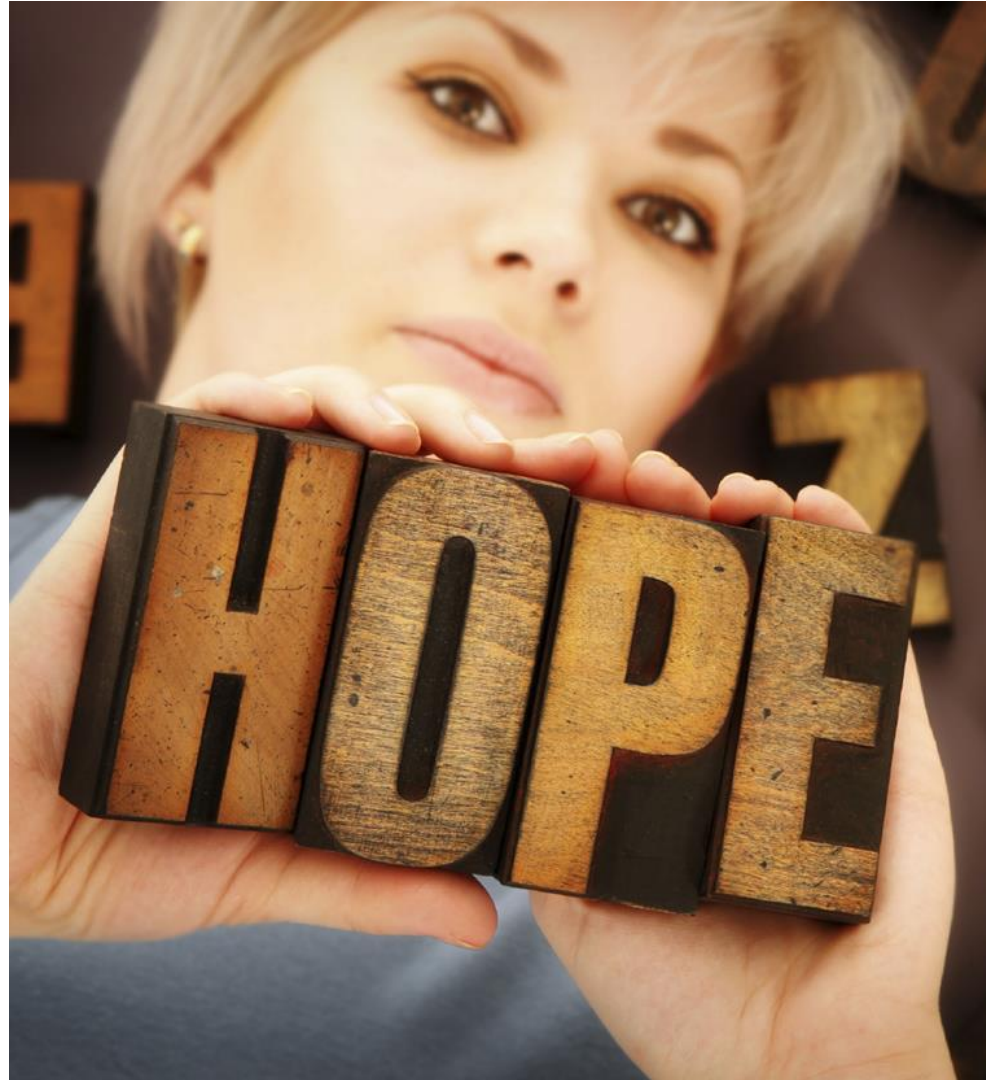
Assertive Outreach and Engagement Status Check

Do organizations have…

- Lengthy and repeated assessment processes?
- Long wait times prior to treatment access with minimal interim contact?
- Multiple appointments prior to beginning treatment?
- Administrative discharges for symptoms of SUD?
- Discharge after 30 days of no-shows or 3 missed appointments?
- High rates of no show or treatment incompletion?
- Limited outreach following missed appointments?

Assessment:
4 Primary Differences

- Assessment is broader in scope. Focuses on multiple life domains

- Assessment expands beyond the challenges of the past and the here and now, and focuses also on the desired future state.

- Assessment is truly an ongoing process.

- Focus on strengths and recovery capital is viewed as equally important to focusing on challenges.

Service Assessments

Changing Our Questions: Examples

- Can you tell me a bit about your hopes or dreams for the future?

- What kind of dreams did you have before you started having problems with alcohol or drug use, depression, etc.?

- What are some things in your life that you hope you can do and change in the future?

- If you went to bed and a miracle happened while you were sleeping, what would be different when you woke up? How would you know things were different?

Assessing
Recovery
Capital

———

WHAT'S THE RELEVANCE?

Individualized Services

A Menu of Options Promotes Relevance, Choice and Ownership

Benefits of a Person Centered Approach?
Example: Western New York Care Coordination Program
Janice Tondora, Yale Program on Recovery and Community Health

OUTCOMES ACHIEVED

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Partnership-Consultant

- **Relationships**

- Professionals support people in making their own choices

- Risk taking is supported even when failure is an option
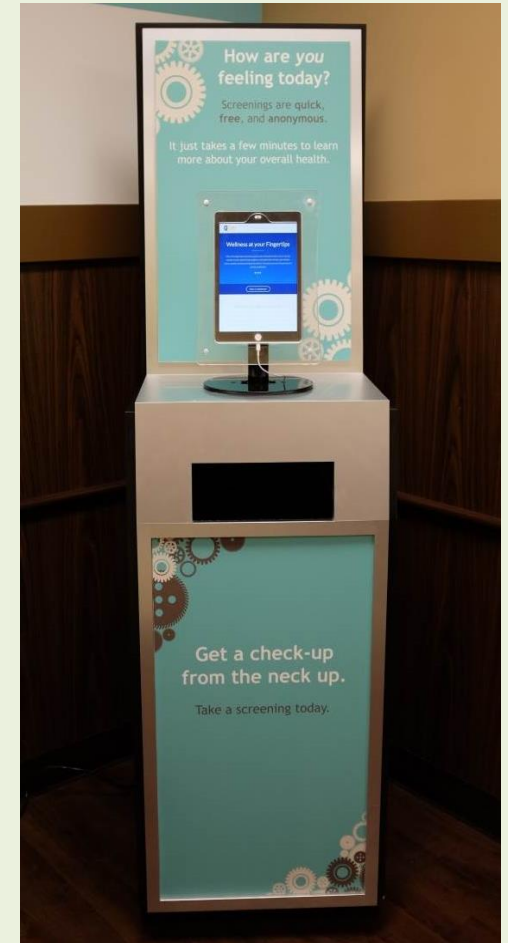
- Doing with, rather than for or to

WHAT DOES IT MEAN FOR SUPPORTS TO BE COMMUNITY-BASED?

Screenings Embedded in Natural Community

Screenings:
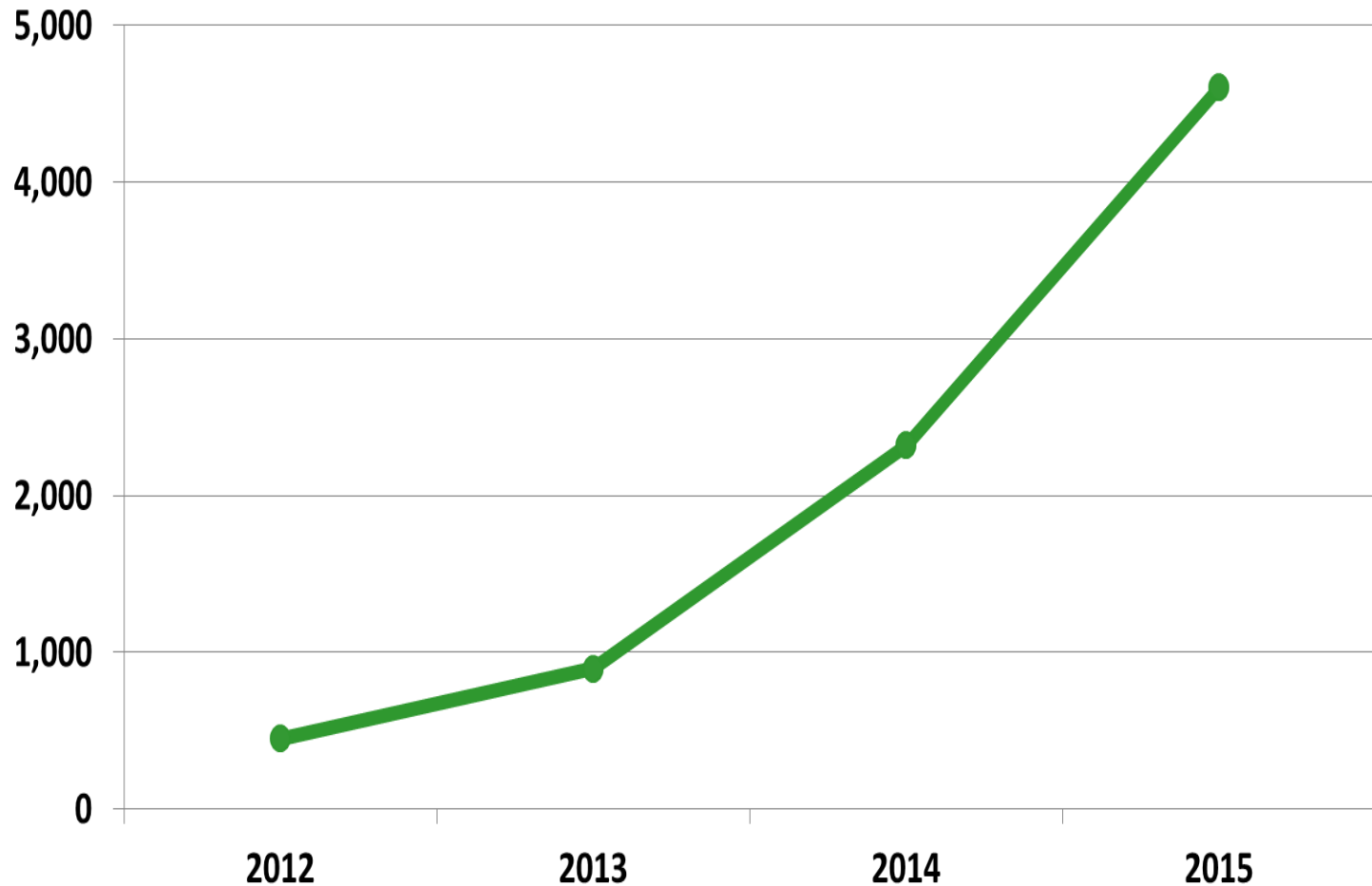
Get a Check UP from the Neck Up

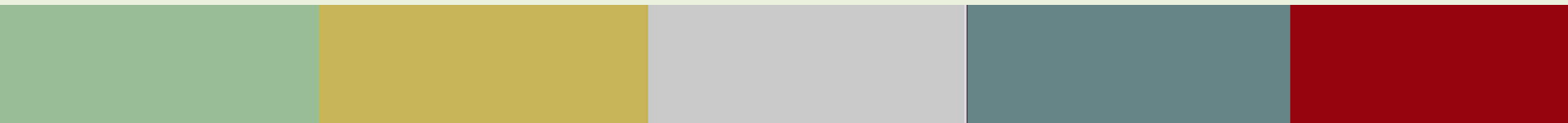- Philadelphia Dept of Behavioral Health and Intellectual Disabilities
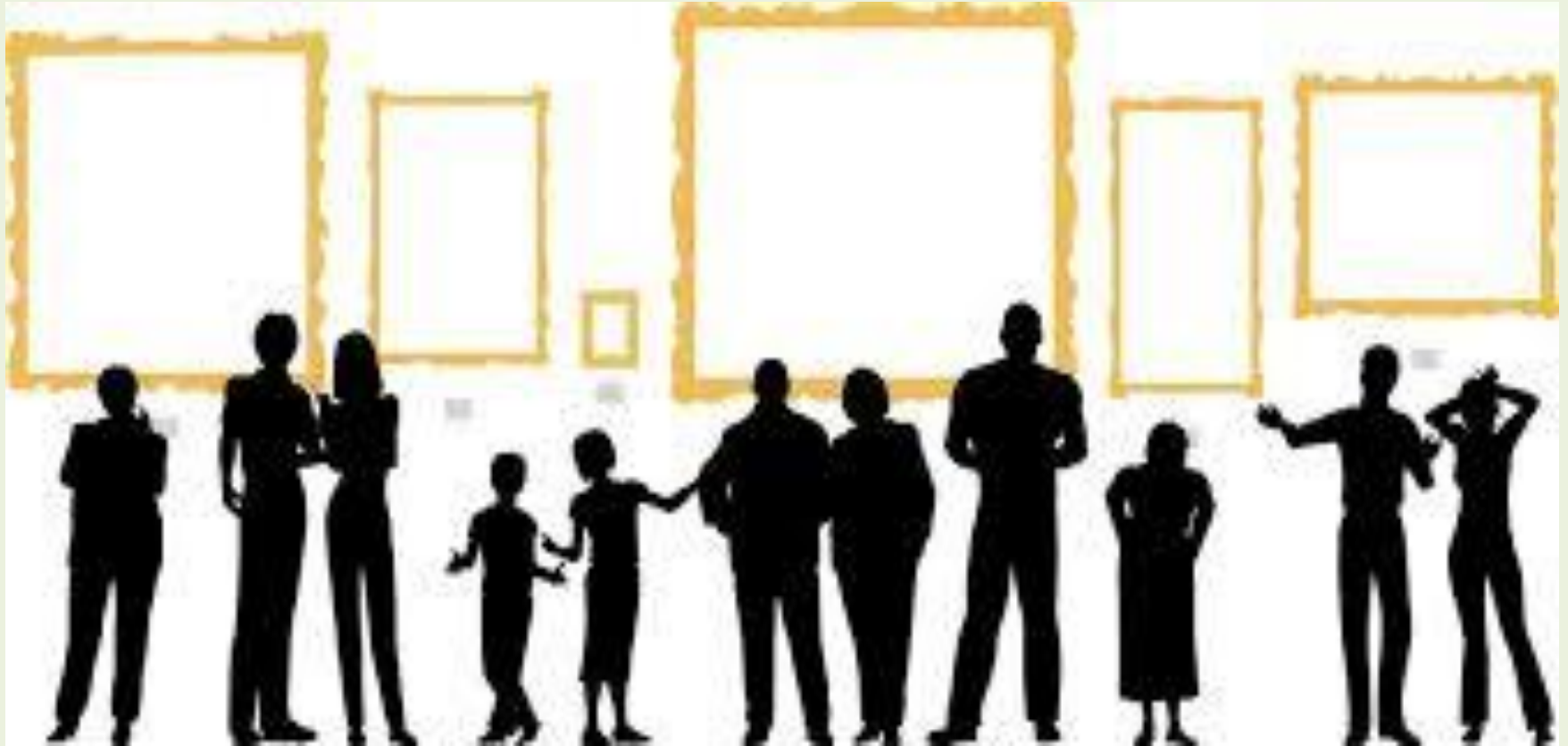
Online Screenings data

Online Screening Numbers per Month: 2012 -2015

Total Cumulative Screenings: 8,273

Gallery Walk

Strategies for Successful Implementation

Don't underestimate what the implementation process entails

3 Approaches

ADDITIVE

Adding peer and community based recovery supports to the existing treatment.

SELECTIVE

Practice and Administrative alignment in selected parts of the organization – e.g. pilot "recovery projects"

TRANSFORMATIONAL

Cultural, values based change drives relationships, practice, policy and fiscal changes in all parts and levels of the organization. Everything is viewed through the lens of and aligned with recovery oriented care.

SAPT – Self-Assessment and Planning Tool

helps service provider agencies translate the recovery vision to effective policies and practices.

RSA – Recovery Self Assessment

helps persons-served and family members gauge the degree to which programs implement recovery-oriented practices.

Used together they support processes for policy development, program planning, staff development, and outcome evaluation.

(SAPT) Self-Assessment and Planning Tool

Three Components:

1. **SAPT Survey**

   Survey respondents should include key administrative staff, clinical supervisors, and select clinical staff.

2. **SAPT Planning and Implementation Guide**

   Description of domain

   Essential Characteristics of most important service components; Barriers, Remedies, and Resources

3. **Linkage to Consumer Outcomes**

   Correlates with the RSA

(Winarski, J., Dow, M., Hendry, P., Robinson, P., and Peters, R. 2009)

Recovery Survey

SAPT – Self-Assessment and Planning Tool

- Administrative
- Treatment
- Community Integration

RSA – Recovery Self Assessment

- Diversity of Treatment Options
- Consumer Involvement and Recovery Education
- Life Goals vs. Symptom Management
- Rights and Respect
- Individually-tailored Services

SOAR:
A Strengths-based Process

Source: Stan Capela & Ariana Brooks-Saunders
HearthShare Human Services

SOAR: A NEW APPROACH TO STRATEGIC PLANNING

- SOAR- Strengths, Opportunities, Aspirations and Results
  - A more strength-based spin than SWOT (Strengths, Weaknesses, Opportunities and Threats)

- A strategic planning framework that…
  - Focuses on strengths
  - Seeks to understand the whole system by including the voices of the relevant stakeholders.

- Helps organizations focus on:
  - What they are doing well,
  - What skills can be improved and
  - What is most compelling to stakeholders.

- Pushes organizations to develop strategic plans that are more dynamic, creative and optimistic.

WHAT IS S.O.A.R.?

Strengths
What can we build on?

Opportunities
What are our stakeholders asking for?

Aspirations
What do we care deeply about?

Results
How do we know we are succeeding?

DESIGNING SOAR

- A strategic planning framework with an approach that focuses on strengths and seeks to understand the whole system by including the voices of the relevant stakeholders.

- Utilizes a "5-I approach" in developing a strategic plan
  - Initiate, Inquire, Imagine, Innovate & Inspire to Implement

- Integrates Appreciative Inquiry (AI) in building strength based strategy

SWOT Versus SOAR

SWOT Analysis	SOAR Approach
Analysis Oriented	Action Oriented
Weakness and Threat focus	Strengths & Opportunities focus
Competition focus- *Just be better*	Possibility focus- *Be the best!*
Incremental improvement	Innovation breakthroughs
Top down	Engagement at all levels
Focus on analysis→ Planning	Focus on Planning → Implementation
Energy depleting- *There are so many weakness and threats!*	Energy creating- *We are good and can become great!*
Attention to Gaps	Attention to Results

SWOT	SOAR
Strengths • Organizational Resources and capabilities • Basis for developing differentiating advantage	**Strengths** • What are we doing really well? • What do our strengths tell us about our skills?
Weaknesses • Absence of strength; lack of resource or capability	**Opportunities** • How do we collectively understand outside threats? • How can we reframe to see the opportunity? • What is the enterprise asking us to do? • How can we best partner with others?
Opportunities • External circumstances that support profit and growth • Unfulfilled customer needs, new technology, favorable legislation	
Threats • External circumstances that hinders profit and growth	
	Aspirations • Considering Strengths & Opportunities, who should we become? • How can we make a difference for our organization and its stakeholders?
	Results How do we tangibly translate our Strengths, Opportunities and Aspirations?

Exploring How Your Community Can Move Forward

- ROSC Steering Committees

- Create a Shared Vision

- Engage diverse stakeholders to partner together in this process

- Identify short-term wins to establish momentum

- Work simultaneously in multiple domains

- Activate and Mobilize the Recovery Community

Next Steps for Planning & Implementation

Identify
- Identify agency priorities and establish a manageable number of goals.

Focus on
- Focus on areas of strength and opportunities

Integrate
- Integrate recovery-oriented services planning with Continuous Quality Improvement (CQI) activities.

Establish
- Establish person-centered decision making as a high priority.

Repeat
- Repeat the SAPT self-assessment and modify plans every 12 months.

Use
- Use the RSA and the SAPT at the same 12 month intervals to provide corresponding outcome information.

5 Future Considerations

Priority
Communications Strategy (stigma, media, universal language, the word "recovery")
Measuring Outcomes and Demonstrating Value; Developing and Disseminating the Value of Recovery
Addressing Fragmentation (recovery communities, systems, stakeholders)
Leveraging the Opportunities Associated with Trends: Opioid Overdoses, Payment Reform, Healthcare Reform
Population Health, Community Wellness, and Social Justice
Developing a Template for Integration of ROSC Strategies to Address Community Concerns

Change almost never fails because it's too early. It almost always fails because it's too late. – Seth Godin

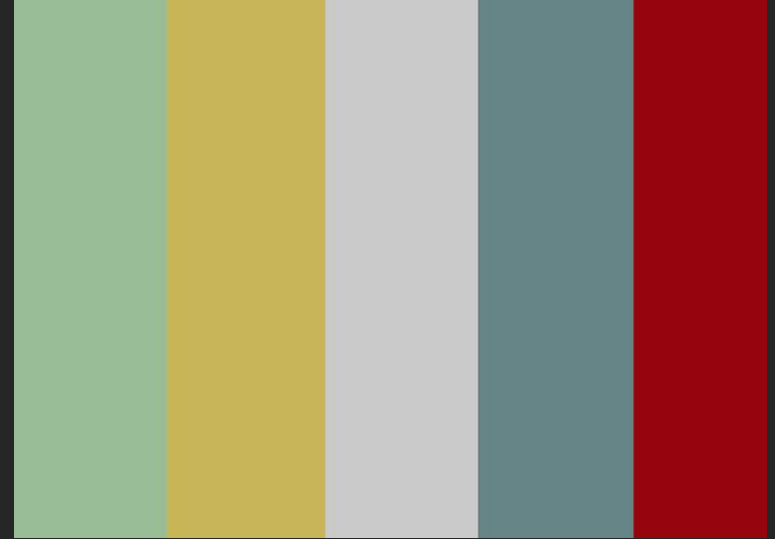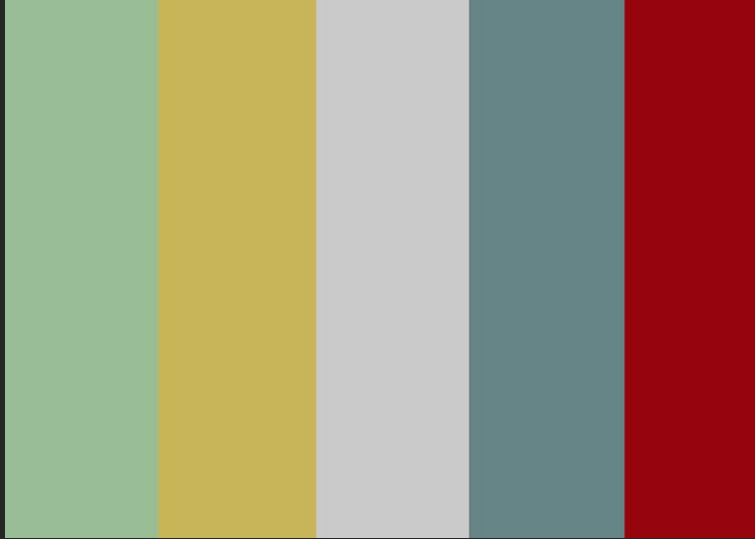The Time for Continued Change is NOW!

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A Big
THANK
YOU!

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