CITY OF PHILADELPHIA
PHILADELPHIA DEPARTMENT OF BEHAVIORAL HEALTH

RECOVERY FOCUSED DAY PROGRAM TRANSFORMATION

START UP AND OPERATIONAL GUIDEBOOK
FIRST EDITION
May 2008

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Chapter 1

OVERVIEW

In early 2006 the Recovery Advisory Committee (RAC) began the process of developing a vision for what a transformed system of services and supports might look like. Their vision called for a radical re-orientation of the current partial hospitalization system. The process with the RAC was followed by an active engagement with providers to begin a partnership which would support this transformation. A Request for Information (RFI) was developed which guided the subsequent development of the Request for Transformation Plans (RFTP). The RFTP called for bold and innovative approaches to transform the current partial hospitalization system to one that supported recovery and a life in the community "like everyone else".

This Day Program Transformation Initiative is intended to fundamentally change many of the underlying concepts and practices associated with the provision of rehabilitation and clinical services in Philadelphia. This change begins with the understanding that meaningful levels of recovery are attainable and constitute a reasonable goal for every day program participant. To promote the achievement of this goal, traditional day programs (Partial Hospital, Social and Vocational Rehabilitation) are being replaced by recovery oriented services and supports that are highly flexible and individualized, choice based, and cost neutral. Symptom management and the maintenance of basic stability will no longer constitute foremost day program objectives.

These services focus on four key pillars: community inclusion, the development of peer culture and peer leadership, family inclusion and recovery planning. To support community inclusion services are no longer restricted to site based programming. Rather, staff supports will follow people into the community in response to individualized recovery goals that participants set for themselves related to a variety of life domains (employment, education, involvement in faith-based activities, etc.). Peer culture is based on the understanding that everyone has resources to offer to another. Programs will develop peer led groups, hire Certified Peer Specialist (CPS) staff, and provide significant opportunities for people in recovery to participate in program design and leadership. Family inclusion practices recognize that key supporters are critical to an individual's recovery process and the system must support the identification, engagement and inclusion of those supporters. Recovery planning moves beyond a limited focus on illness and symptoms to a broad focus on a person's life and bases the development of individualized goals and plans on the individual's dreams and aspirations.

Cultural competence, cost effectiveness and the employment of evidence based practices constitute additional elements essential to transformed programs. Transformation of this magnitude requires change that extends beyond day programs and into every facet of provider agencies (norms, attitudes, policies, procedures, job descriptions, administrative practices, etc.).

The information contained in this Guidebook is the result of highly collaborative partnerships with a number of stakeholders including recovering persons, family members, the State Office of Mental Health and Substance Abuse Services (OMHSAS) and, most notably, agencies that have been involved in piloting this initiative. This partnering process was undertaken to enhance and hasten the achievement of the recovery vision embraced by local stakeholders, as articulated in

both the President's New Freedom Commission Report and the State's Call to Change document. The results achieved by these partnerships have been impressive and should be credited largely to the intensive, collective efforts of pilot providers and their constituents. The successful incorporation of Certified Peer Specialists (CPSs) has also had an especially powerful, positive impact upon the change process.

This Guidebook is intended to accomplish the following:

1) Provide the information needed to successfully guide agencies through the transformation process.
2) Serve as an operational manual documenting expectations governing the effective, ongoing provision of transformed day programs.

It should be noted that the contents of this manual reflect the current status of various elements of this initiative. In some cases information is incomplete pending the further development of policies and procedures resulting from an ongoing mutual learning process. As additional information becomes available, revisions will be made and one or more updated versions of the Guidebook will be issued.

Chapter 2

CORE PRINCIPLES AND EXPECTATIONS

The following principles and expectations serve as the foundation for the day transformation initiative:

a. Choice: All participants will be afforded the opportunity to select from a menu of program supports and services corresponding to their personal interests and recovery goals. Significant input from recovering persons should be sought regarding the development of options menus. Participant choice will apply to in-community and site-based rehabilitation activities as well as treatment options. Selections may be revised as needed to reflect individuals' evolving preferences and goals related to one or more major life domains (education, employment; housing, social/leisure activities, spirituality, volunteerism, etc.). Individualized schedules will be developed based upon the particular activities selected by each participant.

b. Community Integration: Participation in community activities has been positively correlated with recovery and should constitute a foremost objective for every transformed day program. Providers are expected to encourage and assist program participants to explore and engage in a broad spectrum of rewarding community based activities and affirming relationships. This will necessarily involve the routine deployment of program personnel, including peer specialists, into the community to support recovering persons in their efforts to achieve goals related to a variety of life domains.

It is expected that as agencies progress through the transformation process they will develop ever increasing linkages with community support systems that assist people with varied goals including those pertaining to education and employment. Over time, it is anticipated that these efforts will result decreased dependency on program supports. Also note that site-base services should be designed to encourage and equip recovering persons to pursue community-based goals and objectives.

Sample Expectations:

- Staff supported group outings may be used initially to expose recovering persons to a variety of community activities and resources. This activity is intended to assist program participants to identify interests and goals.

- Community based activities may be provided via staff supported small groups (4 participant maximum) or on a one-to-one basis. These activities should be used to pursue objectives corresponding to goals documented in personal recovery plans. Optimal skill development is most likely to occur as a result of teaching and practice in environments where they will be utilized.

c. Peer Culture: Peer culture requires the creation and maintenance of organizational cultures and program milieus that promote peer support, peer leadership and mutual self-help opportunities in culturally competent contexts. Peer to peer supports have proven effective in promoting recovery, conveying hope and motivating participants to pursue positive change. Key elements indicative of peer culture include the involvement of recovering persons in the role of Certified Peer Specialists (CPS) and in other capacities (paid and volunteer) throughout the agency.

Sample Expectations:

- Employing, supporting and effectively utilizing Certified Peer Specialists
- Incorporating peer-led activities into site and community based day services
- Establishing a standing peer government, peer leadership or peer stakeholder group
- Including recovering persons on agency boards
- Employing recovering persons in non-CPS positions/roles
- Establishing personnel policies that encourage hiring recovering persons

d. Family Inclusion: Family inclusion requires the active involvement of recovering persons' family members and supporters at all levels of the service process. Family input into the design and ongoing operation of service delivery systems contributes significantly to the potential for recovering individuals to accomplish their goals. Program participants should be afforded the opportunity to broadly define their "families" to include relatives and/or significant others as they choose.

Sample Expectations:

- Use of family-friendly release forms at intake
- Developing methods to reach out to and engage families/key support people
- Partnering with the Family Resource Network (FRN). This will include routinely initiating referrals to FRN and utilizing their family support resources (see APPENDIX I FRN Resource Information).
- Developing service options to offer to families to assist them and recovering persons (i.e. the availability of family therapy for problem solving, family psychoeducational groups, and involvement of family/supporters in the recovery planning process).
- Inclusion of family members on agency boards
- Involvement of families in the development of programs and policies

e. Enrollment Expectations: Recovery focused day services are intended to provide optimal, individualized supports as efficiently as possible. As a result, it is expected that the average number of service units provided to participants will be substantially less than had been provided via Partial Hospital Programs (PHPs). It is also anticipated that per person decreases in average service units will result in corresponding increases in the number of people who can be enrolled and served. Increased service capacity expectations will be negotiated with individual providers

and will be taken into consideration with regard to the pending development of case rate formulas.

f. Communication and Accountability: The planning and implementation of the day transformation initiative resulted from collaborative partnerships with multiple stakeholders including providers, recovering persons, family members and OMHSAS. Such partnerships are understood to be essential to the continued startup and operation of recovery focused day services. With that in mind, the following mechanisms are intended to ensure ongoing dialogue and collaboration between DBH and agencies undertaking transformation.

- Preliminary meetings with each agency to review their initial transformation plans, discuss the steps needed to pursue full implementation and consider proposed budgets.
- Routine meetings with each agency to facilitate routine face-to-face communication and present opportunities for dialogue, questions, etc.
- Routine status reports (initially quarterly) will be required from providers. These reports will include elements detailed in the Program Evaluation section of this manual as well as other information. See APPENDIX II for the Quarterly Status Report Format (format is pending).
- Agencies are encouraged to work closely with DBH consultants who will be assigned to each provider. The consultants are equipped to provide essential technical assistance and guidance related to the successful implementation of the recovery transformation.

With regard to accountability, it should also be noted that it is expected that recovery transformation will not be limited to day services. Rather, it is essential that every aspect of agencies' adult mental health services be gradually included and restructured as needed to ensure that recovery is promoted and accommodated at every level of provider organizations (administration, treatment, residential, case management, etc.)

g. Inpatient Diversion: It is expected that effective, recovery focused day programs will result in a decreased need for inpatient treatment and crisis services among program participants. This concept is based on the expectation that people will receive the comprehensive, individualized treatment, rehabilitation and peer supports required to prevent or reduce crises and the subsequent need for hospitalization. Lessened use of inpatient care is also an element that has been factored into the DBH cost containment strategy for this initiative, as required by OMHSAS. Concrete and specific plans to achieve this goal will be required to be developed by each provider. These may include warm lines, 24/7 phone accessibility, crisis prevention/intervention plans and the use of advance directives.

Sample Expectation:

- The development of detailed, individualized crisis prevention and response plans for each program participant. Initial plans should be developed at intake,

consistent with a comprehensive bio-psychosocial assessment, and revisited at least annually.

h. 24 Hour Crisis Prevention/Intervention: Providers are expected to establish and maintain round the clock crisis response capabilities for day program participants. These supports should include the ability to rapidly deploy personnel to assist recovering persons in community locations such as places of residence, Crisis Response Centers, etc. It is intended that ongoing supports provided within the context of routine day services should be sufficient to minimize the need for after hours crisis response deployments, however it is imperative that this capability remain available.

Sample Expectations:

- After hours telephone hotline or warm line.
- On-call response personnel who can be deployed as needed to provide crisis intervention/prevention supports.

i. Expanded Hours of Operation: In keeping with the need to flexibly address issues presented by recovering persons, day programs will be expected to modify and extend their schedules to include some evening and weekend hours. Non-traditional service hours are intended to ensure optimal supports for people during periods when they are most likely to feel isolated and vulnerable.

Chapter 3

KEY ELEMENTS TO CATALYZE TRANSFORMATION

The process of transformation that the first six agencies have begun to experience has led to valuable lessons. Several of the most striking of the lessons are summarized here and a fuller treatment of this topic is available in APPENDIX III.

Vision: Organizations who developed a vital and vibrant vision for their own recovery transformation based in the knowledge that a change from business as usual was necessary have been able to create the energy and momentum necessary for the level of transformation called for in this process. The more agencies developed a sense of urgency, a recognition that new strategies were needed and demonstrated an openness to outside influences the more they were able to change quickly and release internal leaders to change

Leadership: It cannot be stressed enough how critical visionary, innovative leadership is to this process. This leadership must embody the values of recovery, seek partnership at all levels, create an organizational environment of safety where innovation and risk taking are expected and rewarded, where success is viewed through the eyes of the program participant and where "failure" is seen as an opportunity for learning and growth. This leadership must start from the top with the CEO/Executive Director but permeate all levels of the system. Support from the top levels of the organization for the direct leadership of the program is critical The nature of this support must be conceptual and pragmatic in terms of removing organizational barriers to the transformation. Recovery focused leadership development, including personnel responsible for oversight of ancillary services, is a critical component of the educational process within each transforming agency.

Management of the change: A change management team must be formed at the outset of this process that includes top level management (or easy access to this level), program leadership staff, psychiatric leaders, direct staff, people in recovery and family members. This team must be empowered to envision the change, direct the change and plan for the change.

It is their responsibility to track the pace of the change, to solicit continuous feedback from all program participants on the change and to be nimble enough to alter plans and processes on the basis of this feedback.

Alignment of concepts and practices are the building blocks of the transformation:
The attention to a recovery orientation is not just a "nice idea" or a change in language. It is a radical re-ordering of the way business is done that affects all relationships within the system. This change in thinking is immediately connected to changes in practice. For example treatment planning which was sometimes done without the person and had little connection to their hopes and dreams is replaced by recovery planning. This is NOT a new label on the same practice. Recovery planning starts with the person's vision of their life and moves from there. Treatment is critical in this approach as it is now conceptualized as one vehicle for removing the barriers that stand in the way of life in the community and is therefore directly connected to the

rehabilitation goals. It is strongly recommended that both program personnel and participants visit and observe the alignment of concepts and practices achieved by other agencies that have already undergone transformation.

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Early elevation of the role of peers and rapid deployment of peer leaders is critical to the process: Programs that developed leadership opportunities for outside peer consultants to jump start the process and/or hired CPS staff as soon as possible gained an increased momentum from the program participants. As participants began to see in concrete ways that recovery is possible, to participate in peer led groups, to participate on stakeholder committees and have their voice not only respected but sought after energy developed that helped other participants (and staff) develop a willingness to try new things and to participate actively in the transformation.

- **The Focus of the Program is outward, not inward:** The true success of these transformed programs will be determined by the degree to which the locus of the program is continuously shifting outward into the community. The tendency to create the perfect site-based day program should be resisted and instead energy and time must be devoted to in-community efforts. Successful programs will have ever increasing staff time deployed in the community and will have growing community partnerships. Programs that stay focused on their programming in the building and view the "in community" time as accessible only to some and as a negligible part of where their energy is directed will not be successful at this transformation. Experience thus far has demonstrated that programs that move rapidly into community encounter activities begin to see their participants differently and the quality of staff/participant relationship is enhanced early on in the transformation.

Chapter 4

READINESS CRITERIA

These Readiness Criteria have been developed to assist DBH in determining the degree to which providers are prepared to implement recovery oriented services and supports. Meeting these criteria can set the stage for the implementation of high quality recovery programs; however it will not guarantee it. Establishing a recovery culture of services and supports is more complicated than these criteria indicate, but the criteria are a step in the right direction. These criteria have been developed based upon the experience to date of the day transformation. They are intended to assist all of us in clarifying expectations and directions. The next Partial Hospitalization programs to be transformed will be provided an array of consultative supports intended to assist them in meeting these criteria. Assisting people in recovery (PIR) and program personnel to understand and embrace the recovery philosophy and orientation will require a concerted effort by all stakeholders.

Program readiness will be determined by:

1. Submission and approval of a "Readiness Plan"
2. Report from the DBH consultant working with the program
3. DBH site visit
4. Finalized by a meeting between program staff, PIRs, (Provider's Change Management Team) and the DBH Day Transformation Team

Once providers have met the Readiness Criteria they will submit their budgets to DBH and subsequent to approval, implement the new service approach under new licensure and payment arrangements.

The criteria are as follows:

1. All programs must prepare a 3-month startup plan. Such plan will be completed in partnership with a peer leadership group and the Change Management Team. The following must be included in the plan:

    a. Describe your vision of the transformed service. The peer leadership group and/or a stakeholder group are required to play a tangible role in the formation of this vision. The vision should reflect their desires, aspirations and hopes regarding recovery. The process of developing the vision should from its inception utilize the core principles of PIR self-direction and choice.
    b. The plan should describe the recovery approach(es) the organization intends to employ; how is this different from what they are currently doing; how will they boldly address the fundamental pillars of the DBH recovery transformation (peer leadership/support, family inclusion, recovery planning & support and community inclusion);

c. Identify how all staff roles will change to accomplish your vision and support your approach;
d. Explain how you will ensure inclusion of all voices (psychiatric staff, recovery coaches (or similar), CPSs, other non-medical staff, PIR & families) in the ongoing program change process, in the development of new roles and in supporting collaborative relationships consistent with your recovery approach. Convening a variety of open forums, as an example, may facilitate the process of inviting input from personnel and participants and serve as opportunities to celebrate successes and identify challenges.
e. Present an orientation plan to be utilized for people in recovery, their families and support networks (including residences, personal care homes, etc.) in preparing them for the transformation of the program;
f. Present your approach for providing staff and peer leaders with support, motivation and assistance as this complex and at times unsettling change process moves forward.

2. The Readiness Plan will include completed job descriptions appropriate to the program approach and a strategy for orienting and training staff to their new roles. The orientation of staff should include an overview of changing roles, including coverage issues (hours of operation), 24/7 response functions, and in-community activities and emphases.

3. Pending DBH authorization, at least one FTE Certified Peer Specialist (CPS) will be hired prior to submission of the Readiness Plan. In addition, appropriate staff will have completed CPS orientation and supervisor training provided by the Mental Health Association of Southeastern Pennsylvania, prior to hiring CPS staff.

4. Programs will present a specific plan for rapid community exposure. The plan should clearly designate dedicated and flexible hours for staff deployment in support of community exposure/exploration with consumers.

5. The Readiness Plan will include the presentation of a transformed program schedule consistent with the overall thrust of the program and one that addresses the key DBH transformation pillars. The plan should be the result of PIR recommendations regarding new curricula and contain designated staff time for the variety of roles to be played. Remember the goal is not to modify your currently existing program and structure but to step completely outside of this box and to create a bold new approach.

6. A Recovery Planning document and process for implementation must also be presented:

   a. Develop and present a format for recovery planning based on the recommendations of the DBH Documentation Workgroup;
   b. Each new recovery plan is to include at least one initial community activity/exposure task;

c. Develop new documentation procedures and expectations based upon the new vision of transformed services, i.e. frequency of progress notes, CPS documentation, comprehensive supervisory approach, etc.;
d. Have completed 10% of new recovery plans prior to startup.

7. The Readiness Plan should indicate progress made in the startup of peer-run groups to date. It is expected that peer-run groups and similar activities will be initiated during the time that these readiness criteria are being fulfilled. PIRs should be scheduled to attend WRAP trainings. WRAP trainings and consumer run services must be included in the new schedule presented.

8. A budget will be submitted per DBH instructions.

9. All required material will have been submitted to OMHSAS in pursuit of a new PRS license.

10. Agency representatives will attend a day program evaluation orientation meeting held by DBH. Following this meeting, each program will complete a baseline administration of the Recovery Tools assessment measures per DBH instructions. The agency will submit the resulting evaluation data from each program to DBH.

Chapter 5

TRAINING

The transformation of the partial hospitalization system to a flexible menu of services and supports requires changes at multiple levels. This change goes beyond language or scheduling and involves a major shift in how those providing services think about what they do and how they practice in their day to day work.

It is recognized that the ongoing need for support and training of practitioners and front line supervisors is vital to the success of transformed services. Training approaches should be varied and may include classroom style sessions; regular opportunities for on-site coaching and modeling; and routine in-service sessions for staff persons designed to trouble shoot issues that arise related to the application of new skills. This could be accomplished at least partially through the institution of a monthly in-service session for staff persons.

A menu of centralized trainings has been designed to facilitate the development of recovery oriented thinking and practice. All trainings listed below are being offered to agencies without charge. Note that attendance for these sessions is either strongly recommended or mandatory:

1. **Recovery Foundations Training** (Strongly Recommended: Provided by DBH) This training provides an overview of recovery concepts and an introduction to recovery oriented practice. It is strongly recommended that all members of agency Change Management Teams attend in addition to as many staff and people in recovery as possible.

2. **Introduction to Psychiatric Rehabilitation** (Mandatory: Provided by Drexel University). This training is mandatory for all staff to meet the requirement for psychiatric rehabilitation licensure.

3. **Day Transformation Core Trainings** (Strongly Recommended: Provided by DBH) These trainings take place on a monthly basis and focus on moving from concept to practice. Presently, Core Trainings in large part are designed to share lessons learned by pilot agencies related to the planning, implementation and operation of transformed services, as well as ongoing staff development.

4. **Level 1 and Level 2 Wellness Recovery Action Plan (WRAP) Training:** Overview for Administrators (Mandatory): This session is for administrators and supervisors, and includes an interactive introduction of key concepts, an explanation of the plan structure and an explanation of the importance of using this tool to empower PIR to direct their personal recovery process. Level 1 (Strongly Recommended): This two-day introduction training is open to all PIR and all others within the DBH/MRS system. This training walks individuals through the detailed process of developing a personal WRAP. Level 2 Facilitators Training (Strongly Recommended): This *training* involves 5 days of intensive instruction that presents the skills needed to be an effective WRAP facilitator.

At the conclusion of this training, graduates are certified to conduct WRAP groups. Level 3 Masters Level (Recommended): This training is offered by the Copeland Center and is designed for people interested in developing additional expertise, becoming advanced WRAP facilitators, and equipping people to provide WRAP training.

5. **Certified Peer Specialist Supervisory Training** (Mandatory for CPS supervisors): This two day training is designed to equip supervisors of CPSs with the knowledge and skills to operate a peer specialist service. Participants will learn theoretical, historical and implementation aspects of recovery and community integration as it relates to peer specialist services. Participants will also learn Performance Management concepts and skills as an effective tool to maximize human potential in the role of manager while implementing a new service.

6. **Trainings for people in recovery** (Strongly Recommended: Provided by DBH)
   While most trainings include the participation of people in recovery, there are several specifically designed to develop skills and knowledge in this group. These are outlined in APPENDIX IV.

A training calendar is distributed on a regular basis. The most recent calendar is attached as well as a guide to other trainings offered by DBH. Consideration should be given to the staff resources needed to cover program operations when personnel are attending trainings, etc., e.g., temporary personnel, relief staff, students, or volunteers. Agencies are also encouraged to consider training regarding the general management of organizational change.

In addition to the sessions offered by DBH or Drexel, agencies should provide in-house training that is specifically geared to their developing model. The timing and pacing of this training in relation to the overall transformation is critical. It is strongly recommended that agency training plans provide for the supervised application and practice of new concepts. DBH consultants can serve as an invaluable resource related to the sharing of lessons learned by other providers and in supporting the development of focused, manageable training schedules. During the start up period, your consultant will discuss and support attendance at all of the trainings offered; will facilitate discussions and observe applications of skills learned in these sessions; and will provide ancillary training on-site, as needed, to strengthen learning and opportunities for application with feedback.

It is expected that at the end of the first year agencies, with support of their consultant, will plan for additional trainings in year two and three. This plan should include the introduction of Evidence Based Practices (IMR, IDDT, Supported Employment and Family Psychoeducation).

Chapter 6

DOCUMENTATION AND RECOVERY PLANNING

In keeping with the system transformation principle of partnership, the documentation workgroup was formed in the summer of 2007. This group was composed of representatives from the first eight agencies, a representative from OMHSAS, representatives from CBH and the day program consultants. The task of the group was to develop a consensus to guide agency development of documentation processes. The group identified the following overarching principles of documentation:

1. **Process Oriented:** The purpose of documentation is to track the journey of the person in recovery (PIR) and their supporters toward recovery.
2. **Relationship Based:** It reflects the individual and their relationship with staff. What is written on paper is the story of what happens between the person in their journey and the way the staff supports them.
3. **Flexible and allows for evolution:** Documentation requirements are flexible, what is written reflects changes and new decisions on the road to recovery.
4. **Person Driven:** The PIR is the driver of the planning process and documents the overall process (as they are able) with staff support. Assessment is a constant process involving an ongoing conversation between the person and their staff supporters.
5. **Individual:** What is written reflects an understanding of the PIR, their culture, their strengths, their hopes and dreams. No two records look alike.
6. **Integrated:** The thinking of the PIR and all supporters are reflected in the documentation. The written document reflects the process of integration that is happening between the participant and their staff and between staff.
7. **Streamlined:** Documentation is streamlined with minimal repetition and with minimal requirements so the focus is kept on the PIR, their relationships and their process of recovery, not on completing paperwork.
8. **Goal oriented:** Documentation reflects agreement on what the markers of progress are and who is responsible for each step in that process. Clear delineation of roles between the PIR and various staff supporters.
9. **Strength Based and reflective of challenges and barriers:** Documentation reflects a perspective that looks first at the individual's abilities and then at the challenges they confront within as well as the barriers in the system and society which interfere with the full realization of their hopes and dreams.
10. **Respect:** In tone and language documentation reflects a deep respect for the PIR. Language is person first, whenever possible in the person's own words and recovery oriented.

In addition to these principles the group has agreed on a clear commitment to an integrated recovery plan that incorporates treatment and rehab into one plan. This plan is to be a "working" document that is updated as often as the PIR's progress and individual goals change. The process of recovery planning is markedly different than that of "treatment planning". As one participant described it "treatment planning is about what staff does to me, recovery planning is

about what I want for my life and how you can help me." Guidelines developed to date for recovery planning are as follows:

This approach to recovery planning supports the values of the DBH Day System transformation and provides a simple pathway from traditional treatment planning to participant-driven recovery planning. It is assumed that programs will institute a more comprehensive approach as their recovery practices evolve.

It is recommended that the following principles guide recovery-planning practice:

- It is assumed that Recovery Coaches (RC, or similar) have assumed a "caseload" and are conducting frequent (weekly) **individual meetings** with these participants to both construct a recovery plan and complete its tasks.
- The overall thrust of the DBH Day System transformation is to partner with people in recovery to create the necessary supports that can lead to the **enrichment of their lives in the community**. The approach to, and the content of the recovery plan should evidence this thrust.
- The **centrality of the relationship** between the PIR and the RC cannot be overemphasized. The transition of this relationship from one primarily facility-based to one that is community-based is in-and-of-itself transformational and should be viewed as such.
- The pace, ambitiousness, content and outcomes of the recovery plan are assumed to be highly variable, individualized and **dependent on the aspirations and motivation** of the person in recovery. Part of the RC's challenge is to provide the support, coaching, persistence, empathy, ideas etc. that encourage PIRs to pursue the life they desire. Critical here is the communication of hope.
- It is anticipated that as programs progress through the first year of program start-up, **additional practices and resources** will be brought to bear in support of recovery planning including varieties of peer supports, family inclusion, employment and educational supports, etc.

Steps to the Process: Preparation, Engagement and Action

Step 1: Preparation. For those persons who have been Partial Hospital Program (PHP) participants, it is recommended that a full review be completed of their current program involvement, historical vulnerabilities, stage of recovery, strengths/assets, quality of support network, as well as their capabilities, aspirations and hopes. This information can be gathered from program files, other staff, family members and participants themselves.

Step 2: Engagement and the creation of the Recovery Plan. The primary thrust of this step is to partner with the person in creating a plan that can enhance their life in the community. A trusting and supportive relationship is assumed. Recovery planning begins with individual sessions that include conversations designed to accomplish the following:

- Discuss with the person the shift being made in how recovery planning will be conducted and how it differs from treatment planning.

- Discuss how the new program approach provides the PIR and the RC with the flexibility to engage in community opportunities of interest to the person in recovery. Provide examples. Discuss this.
- Explore with the person in recovery their interests and aspirations and encourage exposure to community opportunities. Explore the DBH assessment scales recently completed by the PIR. Together discuss concrete examples that may align with their interests.
- Identify 1 or 2 concrete actions that will occur within the next 1-2 weeks. Be flexible, but be concrete. Establish a commitment to complete these actions. Schedule them. Identify any barriers to completing them. Work together to eliminate barriers. Complete an initial recovery plan document.

Step 3. Carry out the plan - sustain the plan. Together the PIR and the RC will carry out, document progress and refine the plan as tasks are completed and follow-up tasks are created.

SUMMARY:

Process: Prepare, Engage, Explore, Concretize and Act

Stress simplicity, partnership and action!

Celebrate accomplishment

REMEMBER THAT RECOVERY PLANNING CONVERSATIONS HAPPEN MOST EFFECTIVELY IN COMMUNITY SETTINGS AS THIS LEADS TO A DEEPER AND RICHER CONVERSATION.

The work of this group is expected to continue into 2008. At the time of the release of this manual (Spring 2008) a small workgroup comprised of agency representatives, consultants, CBH staff and OMHSAS representation is meeting regularly to bring together the documentation principles, the PRS regulations, the outpatient regulations and CBH expectations. More guidance will be forthcoming.

Chapter 7

CHANGING ROLE OF RECOVERING PERSONS

One of the key lessons learned in thus far in the transformation process is that many people in recovery will exceed expectations when given an environment that promotes the full expression of their hopes and dreams and that provides new opportunities for giving back and entering the community. In the first agencies, staff and people in recovery alike were surprised by the wealth of untapped resources that emerged when people were given new opportunities to participate within peer led groups and to relate to staff in less hierarchical relationships. Staff find their practice enlivened by seeing long term members begin to express and achieve new hopes and dreams. Staff also express hope for others who may not yet have grabbed hold of their recovery process.

In a traditional system the role of the person in recovery (PIR) was one of being a patient or client in a Partial Hospital Program (PHP). The goals for those persons involved gaining stability, participating in program activities and meeting program goals. In a transformed program the PIR moves from this passive role to an active role where they direct their lives with the support of program staff. This involves exploring their goals in terms of their hopes and dreams for their life. It involves identifying activities, organizations and people in the community that they consider to be important to their recovery process. The PIR finds ways to give and receive support not only from staff but from other peers in the program.

The development of this mutual support among people in recovery has proven to be another powerful catalyst for change. Certified Peer Specialists have been critical in this process by creating peer led groups where people who have been in program together for years in many cases, begin to engage each other on a human level, to share common interests and to share resources with one another. People have begun to call each other in the evening, to make plans to meet outside of program time and to develop real relationships with each other. The energy of these connections between program participants in turn creates a context to draw other people into their recovery process in a more active way.

The more active stance of people in recovery is also reflected in the shift from treatment planning, historically a passive process, to recovery planning. Recovery planning is directed by the PIR and takes into account the persons hopes and dreams for their whole life, not just the time they spend in the program or the management of medications and symptoms. It involves an active partnership between staff and PIR together exploring options and alternatives, developing choices and plans and evaluating successes and challenges. The PIR is the active director of their recovery not the passive recipient of treatment. The person sets the goals and the standards for success within the context of this mutually supportive relationship.

Peer stakeholder groups are a critical element of developing leadership by people in recovery. The form of these groups varies from program to program, depending on the culture of the agency and the desires of the members but they share common characteristics. They meet regularly with a defined group of people who have been identified through a process as leaders within the program. They have real decision making authority in partnership with staff. They

set direction for the program and are active in resolving disputes and difficulties that may arise. They may take on leadership roles within the program as part of stakeholder groups. They are encouraged to identify key supporters in their lives (biological family and others) who are critical in their recovery journey.

This transformed role may not come easily to all PIR or staff. It is critical that the environment facilitate this change by:

- Insuring that PIRs are free to voice their concerns without fear of being judged as non-compliant. If recovering persons believe their grievances are not being taken seriously by staff, they can take their issues to the agency's peer stakeholder group to be resolved.
- Recognizing that for long term program participants the role of "patient/client" has been learned and will need to be unlearned.
- Providing a broad range of groups that reflect the interests and identified needs of the program participants and contribute to skill development.
- Recognizing that the goal of independent community activities with people who are important in the PIR's life is a critical outcome of the program. Support and encouragement for these activities by program staff is crucial.
- Recognizing that each person's pathway to recovery is different and the timing is different. Some people may appear stagnant for an extended period of time and then rapidly progress. Others may have a more step by step recovery process.
- Creating an environment that supports risk taking in terms of trying something that might not have been tried before and that supports learning from things that don't work out as expected. (Respecting the dignity associated with taking risks and exercising choice).
- Developing an information packet or handout which outlines the program expectations and clear procedures for filing grievances and complaints by program participants.

Chapter 8

PROGRAM EVALUATION & MONITORING

Program evaluation and monitoring efforts are intended to provide day programs engaged in transformation and DBH with information that will support program improvement, increase understanding of the transformation process, and assess the extent to which services are achieving outcomes consistent with core concepts that serve as the foundation for recovery transformation. The evaluation and monitoring measures were developed through dialogue with and lessons learned from pilot service providers and from knowledge culled from relevant literature.

OVERVIEW

The monitoring and evaluation of day programs will encompass both *process* and *outcome* measures (See APPENDIX V, Philadelphia Day Program Transformation Logic Model depicting the Context, Values, Strategies, and desired Outcomes for this initiative). The focus of the day **program monitoring** is process indicators. ***Process indicators*** are intended to capture information about program activities. Process measures were chosen to capture activities that are believed to facilitate achievement of desired outcomes.

The focus of the day **program evaluation** is outcome indicators. ***Outcome indicators*** are intended to capture information about the progress of the program and program participants on key transformation objectives. These include both ***short-term outcomes*** that are envisioned as achievable within the first year of the transformation process, and ***intermediate- and long-term outcomes***, which are expected to be achievable in the second year or beyond. Collection of data for all of the evaluation measures will begin prior to transformation in order to gather baseline information.

The monitoring and evaluation focus on **four key components of transformation**: Recovery Support, Community Participation, Family Involvement, and Peer Leadership/Peer Culture. Recovery Support is the most global of these, while the other three relate to specific domains of recovery.

PROGRAM MONITORING

As mentioned above, the focus of day transformation program monitoring is the program process. In other words, the monitoring is intended to gather information about the activities, policies, and processes within day programs. Program Monitoring will occur via site visits during which DBH personnel will review charts and interview program administrators and staff. Examples of process indicators reviewed via the on-site monitoring process include:

Recovery Support: Process Indicators

- Development of individualized recovery plans with clear goals related to the person's life in multiple major life domains.
- Establishment of 24/7 on call.

- Creation of plan for infusion of crisis prevention strategy in program.
- Scheduling of WRAP groups determined by program participant preferences and needs.
- Implementation of Evidence-based Practice(s).
- Streamlined intake process with same-day enrollment.
- Strengthened connection/partnership with CRC and local inpatient units.

Community Participation: Process Indicators

- Incorporation of educational and vocational goals in recovery plans.
- Evidence of day program linkages to community partners that offer services and supports in key life domains (e.g., education, vocation, social support, etc.).
- Evidence of innovative community partnerships.

Family Involvement: Process Indicators

- Documentation reflects regular contact with and outreach to family members/key supporters.
- Evidence of policies and services encouraging family inclusion and support.
- Evidence of inclusion and meaningful engagement of family / key supporters in events.

Peer Leadership/Peer Culture: Process Indicators

- Development of policies and practices to promote peer leadership and peer culture.
- Peer leadership group with format/structure that fits the agency culture.
- Number of on-site peer-led groups per week.
- Documentation of referrals to naturally occurring mutual self-help groups outside the program, including groups within the physical health arena (e.g., diabetic support groups, grief groups, etc.).

PROGRAM EVALUATION

As mentioned above, the focus of day transformation program evaluation is program outcomes. In other words, the evaluation is intended to gather information about changes in the program and program participants and progress toward program goals. The outcome measures are designed to capture different levels of the transformation impact. ***Participant-level outcomes*** are intended to assess the progress of program participants over time. In other words, they evaluate how people change as a result of their participation in the program, specifically in relation to key indicators of participant recovery. ***Program-level outcomes*** are intended to assess changes in the program over time, specifically in relation to key indicators of the recovery transformation process. The Program Evaluation will include both data gathered by the programs and data gathered by DBH or other agencies, as described below. Examples of outcome indicators for the evaluation include:

Recovery Support: Outcome Indicators

- Successful transitions from day program.

- Decreased CRC Utilization (utilization of CRCs by recovering persons during the year prior to their entering transformed services will be used to establish baselines for this measure).
- Improved participant recovery status and quality of life.

Community Participation: Outcome Indicators

- Increased in-community units of service
    - Percentage of total program UOS provided in-community per month.
    - Percentage of total active program participants who are receiving in-community supports per month, based on UOS reporting.
    - Average number of in-community UOS being provided per month to persons receiving in-community supports.
- Increased independent community involvement by program participants:
    - Total and average number of community activities participated in for at least one day.
    - Total and average number of days of community participation.
    - Percentage of participants participating in independent community activities.
- Increase in number of program participants connected to educational and employment options outside of the program.

Family Involvement: Outcome Indicators

- Increased engagement of family members / key supporters.
- Increased number of family member / key supporter referrals to FRN.

Peer Leadership/Peer Culture: Outcome Indicators

- Increased CPS activity / units of service.
- CPS retention.

Evaluation Data Submitted by the Day Programs

There are several sources for the information DBH will include in the evaluation of transforming day programs. One source is information collected by the programs and submitted to DBH. The following describes information that programs are responsible for collecting, including:

- Units of Service;
- Recovery Support Tools (Assessment Scales);
- Certified Peer Specialist (CPS) Activity;
- Certified Peer Specialist (CPS) Retention;
- Successful Transitions from Day Program.

As noted in the next section of this chapter on "Data Gathered by DBH," the evaluation will also include other information which will be collected by DBH or other organizations (e.g., Family Resource Network), in some cases with assistance from the programs.

Units of Service

Units of Service (UOS) data will be limited to face-to-face contacts involving staff and service recipients. All site-based time will be considered face-to-face and reported as such. Face-to-face services delivered in community settings will also constitute reportable UOS. It is understood and expected that there will also be unreported time devoted to collateral contacts, phone calls, etc.

Agencies will be required to submit UOS data for both CBH and non-CBH program participants. MA reporting to CBH will occur via existing claims submissions**.** UOS data for both CBH and non-CBH participants will be reported to DBH Research Information Management (RIM) via 3 PACs (Outpatient, PRS Site-Based, PRS In-Community). Additional reporting detail will be forwarded to providers in advance of their transition to an alternative payment arrangement (see Financing section).

Recovery Support Tools (Assessment Scales)

The Recovery Support Tools are meant to gather information that can be used with individual participants to support recovery as well as to examine how program participants as a group are doing at particular points and over time. The following scales will be routinely administered by agency personnel to each program participant at "baseline" prior to engagement in transformation activities and on a biannual basis (April and October). These scales will also be administered to participants upon admission to and transition from the program. Agencies will enter the scale data into an Excel spreadsheet provided by DBH and submit the spreadsheet to DBH Continuous Quality Improvement (CQI) for summarization and analysis. Additional instructions regarding the scales and submission of scale data will be provided for all agencies prior to the initial baseline administration.

- Community Participation Scale measures the extent to which participants have engaged in activities in the community over the course of the preceding month.
- Recovery Assessment Scale measures participants' attitudes concerning a number of indicators that reflect recovery status (goals, optimism, self acceptance, etc.).
- Quality of Life Scale tracks the impact of recovery focused programming on the overall quality of participants' lives, across a number of domains (employment, family and other relationships, etc.).

Certified Peer Specialist (CPS) Activity

The quantity and types of services being offered by CPSs is a measure intended to reflect establishment of peer leadership and peer culture. In order to gather information about the quantity and types of services being offered by CPSs, day programs will submit CPS units of service. In response to provider concerns, there will be no CPS client-level documentation or reporting. Programs will report CPS staff units of service in four categories: Group site-based, Individual site-based, Group in-community, and Individual in-community. This information will be reported to DBH Research and Information Management (RIM).

Certified Peer Specialist (CPS) Retention

The extent to which agencies are able to retain personnel employed as Certified Peer Specialists is a measure intended to serve as a proxy reflecting peer culture. In order to gather information about retention of CPSs, day programs will be asked to provide general information about CPSs who have left their agency or who have moved into another position within the agency (e.g., length of time with day program, reason for departure or transition). The exact mechanism for gathering this information has yet to be determined.

Successful Transitions from Day Program

An important program goal is to support the ability of program participants to successfully transition from the program. To this end, one outcome indicator will pertain to successful transitions from the program. The exact definition of this indicator and mechanism for gathering this information has yet to be determined.

Evaluation Data Gathered by DBH

The evaluation will also include information collected by DBH or other organizations, including the following:

- Crisis Response Center (CRC) Utilization;
- Family Resource Network (FRN) Referrals;
- Impact on Other Services;
- Program participant and staff perceptions of the program (via focus groups).

CRC Utilization

CRC episodes involving day program participants will be tracked and monitored via Person Plus data collected by DBH Research and Information Management (RIM).

Family Resource Network (FRN) Referrals

The Family Resource Network (FRN) will document referrals they receive involving family members of persons served by agencies operating transformed day programs. A summary of this information will be submitted by FRN to DBH Continuous Quality Improvement (CQI). This process was developed in collaboration with FRN and pilot providers and is intended to constitute a proxy measure reflecting family inclusion.

Impact on Other Services

It is anticipated that transformed day programs will impact utilization rates of other key services including Psychiatric Inpatient and Targeted Case Management. Utilization rates will be monitored to assess impacts on these services and to determine the overall cost effectiveness of day program transformation.

Program Participant & Staff Perceptions of the Program

Focus groups with program participants and program staff will be facilitated by DBH personnel and DBH consultants at a group of initial participating programs at the conclusion of the first

year of the transformation process. As part of an evaluation visit, agencies will be asked to provide space and resources for two focus groups. The groups will discuss topics such as perceived changes within the program, changes in staff and participant roles within the program, relationships within the program, relationships between the program and the community, connections to participants' family / key supporters, and program successes and challenges.

PARTICIPANT SATISFACTION

In addition to the above-mentioned process and outcome measures, feedback from recovering persons concerning their levels of satisfaction with transformed services will constitute an essential complement to the program evaluation. The Consumer Satisfaction Team (CST) will conduct visits to the transforming day programs to solicit program participant feedback about the programs.

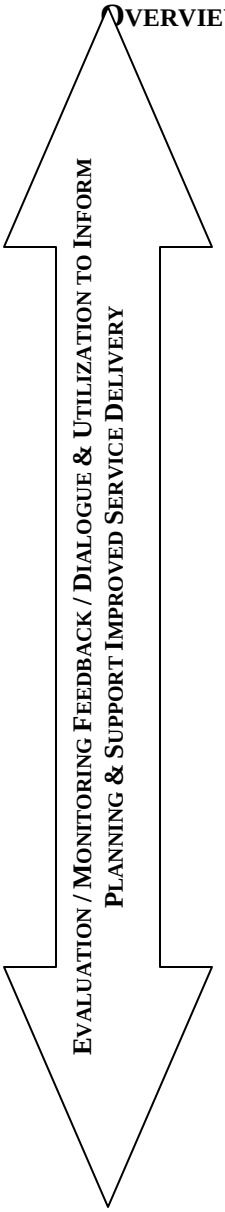
DATA UTILIZATION: DAY MONITORING AND EVALUATION

Data is only beneficial if it is used. To support data utilization, DBH has worked with day provider agencies to identify measures that provide useful information. In addition, there will be regular opportunities for feedback and discussion of evaluation and monitoring findings through forums including both provider and DBH stakeholders. And each provider will receive agency-specific reports from DBH, which will include aggregated system-wide performance data for comparative purposes. Evaluation/Monitoring meetings will occur on a biannual basis. Evaluation/Monitoring summary reports will be distributed annually, though for some components (e.g., Recovery Support Tools) there may be more frequent sharing of findings.

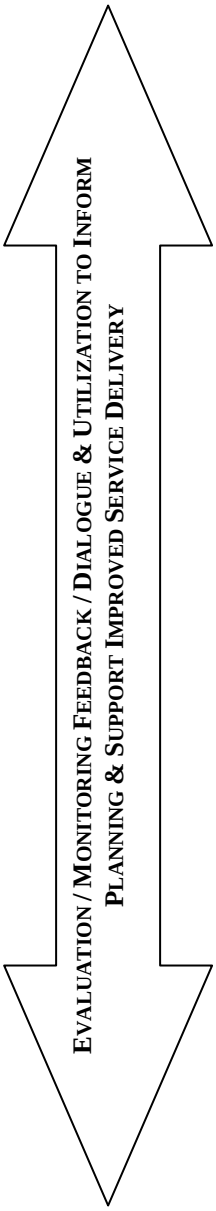
A key goal of the evaluation and monitoring process is to support critical thinking about and use of the evaluation and monitoring findings to inform program planning and decision-making. Day programs will be expected to engage in dialogue with DBH and internally within their agencies and programs about evaluation / monitoring findings and identified strengths, needs, and challenges. Based on this dialogue, day programs will be expected to develop plans that outline recommendations and strategies for addressing these recommendations. DBH will work with the programs to provide technical assistance and assess progress and challenges in regards to these plans on an on-going basis.

The Program Monitoring and Evaluation Overview Table below provides information about data sources and envisioned timelines (short-, intermediate-, long-term) for each process and outcome indicator.

DAY TRANSFORMATION: PROGRAM MONITORING AND EVALUATION OVERVIEW TABLE



Recovery Transformation Domain	Measure/Indicator	Indicator Type	Timeline for Achievement	Who collects data	Data Source
Recovery Support	Development of individualized recovery plans with clear goals related to the person's life in multiple major life domains.	*Process*	Short-term	*DBH*	On-site Monitoring
	Establishment of 24/7 on call.	*Process*	Short-term	*DBH*	On-site Monitoring
	Creation of plan for infusion of crisis prevention strategy in program.	*Process*	Short-term	*DBH*	On-site Monitoring
	Scheduling of WRAP groups determined by program participant preferences and needs.	*Process*	Short-term	*DBH*	On-site Monitoring
	Implementation of Evidence-based Practice(s).	*Process*	Intermediate / Long-term	*DBH*	On-site Monitoring
	Streamlined intake process with same-day enrollment.	*Process*	Intermediate / Long-term	*DBH*	On-site Monitoring
	Strengthened connection/partnership with CRC and local inpatient units.	*Process*	Intermediate / Long-term	*DBH*	Focus Grps & On-site Monitoring
	Decreased CRC Utilization	*Outcome*	Intermediate / Long-term	*DBH*	RIM PersonPlus
	Successful transitions from day program.	*Outcome*	Intermediate / Long-term	**Day Program**	**TBD**
	Improved participant recovery status and quality of life.	*Outcome*	Intermediate / Long-term	**Day Program**	Recovery Tools
Community Participation	Incorporation of educational and vocational goals in recovery plans.	*Process*	Short-term	*DBH*	On-site Monitoring
	Evidence of day program linkages to community partners that offer services and supports in key life domains (e.g., education, vocation, social support, etc.).	*Process*	Short-term	*DBH*	Focus Grps & On-site Monitoring



Recovery Transformation Domain	Measure/Indicator	Indicator Type	Timeline for Achievement	Who collects data	Data Source
	Evidence of innovative community partnerships	*Process*	Intermediate / Long-term	*DBH*	Focus Grps & On-site Monitoring
	Increased in-community units of service.	*Outcome*	Short-term	**Day Program**	UOS Reporting
	Increased independent community involvement by program participants.	*Outcome*	Intermediate / Long-term	**Day Program**	Recovery Tools
	Increase in number of program participants connected to educational & employment options outside of program.	*Outcome*	Intermediate / Long-term	**Day Program**	Recovery Tools
Family Involvement	Documentation reflects regular contact with & outreach to family members/key supporters.	*Process*	Short-term	DBH	On-site Monitoring
	Evidence of policies and services encouraging family inclusion and support.	*Process*	Short-term	DBH	On-site Monitoring
	Evidence of inclusion and meaningful engagement of family / key supporters in events.	*Process*	Short-term	DBH	On-site Monitoring
	Increased engagement of family members / key supporters.	*Outcome*	Intermediate / Long-term	DBH	Focus Groups
	Increased number of family member / key supporter referrals to FRN.	*Outcome*	Intermediate / Long-term	FRN	FRN tracking
Peer Leadership and Peer Culture	Development of policies & practices to promote peer leadership & peer culture.	*Process*	Short-term	DBH	On-site Monitoring
	Peer leadership group with format/structure that fits the agency culture.	*Process*	Short-term	DBH	On-site Monitoring

Recovery Transformation Domain	Measure/Indicator	Indicator Type	Timeline for Achievement	Who collects data	Data Source
	Number of on-site peer-led groups per week.	*Process*	Short-term	DBH	On-site Monitoring
	Documentation of referrals to naturally occurring mutual self-help groups outside the program, including groups within the physical health arena (e.g., diabetic support groups, grief groups, etc.).	*Outcome*	Intermediate / Long-term	DBH	On-site Monitoring
	Increased CPS activity / units of service.	*Outcome*	Short-term	**Day Program**	CPS Activity Reporting
	CPS retention.	*Outcome*	Intermediate / Long-term	**Day Program**	**TBD**

Chapter 9

ROLE OF THE CONSULTANT

DBH will provide transformation consultation resources without cost to agencies. Consultants will play an essential role in guiding providers through the complex transformation process. Consultation will be provided by professionals with clinical backgrounds, strong recovery orientations, experience in transforming systems beyond Philadelphia, and a clear commitment to advancing this transformation initiative. The consultants have had extensive involvement with the agencies that have already undergone transformation and, as a result, they are also able to share invaluable "lessons learned" information. Key aspects of their roles include the following:

1. **Conveying and promoting a sense of positive anticipation and urgency among agency and program leadership**: One challenging aspect of this undertaking involves the need to continue operating programs while they are undergoing transformation. There is potential for day-to-day realities to cloud the focus on transformation and impede progress toward this goal. Consultants will assist agency leadership and Change Management Teams (CMTs) to continue their collective efforts to press on and accomplish the desired transformation in a timely fashion.

2. **Engaging agency and program staff at all levels in an understanding of the change process**: The process of program transformation is similar to the recovery journey that individuals undertake. When understood in this context, the process can promote an enlightened learning experience for all involved. Consultants can sustain the transformation focus within programs, while reassuring staff and participants that their feelings and reactions are common to people involved in this change process.

3. **Conceptual grounding and technical assistance related to practice:** Consultants can translate and apply recovery concepts to the day-to-day experience of staff working with program participants. They can assist with training (recovery concepts, recovery planning, etc.) and with concrete change activities (staff meetings, retreats, leadership coaching).

4. **Assisting in the management of the change process**: The consultant can support CMTs throughout the various phases of the transformation process, including deciding when tangible changes need to take place (e.g. changing the schedule) and making connections between new practices (e.g. recovery planning and how it leads to community integration activities).

5. **Coaching and bringing focus to the four pillars of the transformation (peer culture and support, community integration, family inclusion and collaborative recovery planning)**.

6. **Creating an environment of peer (staff) learning and support**: Consultants can share lessons learned by other agencies and facilitate instructive peer-to-peer connections between local provider "experts" and provider personnel who are still in the process of transforming their services.

Chapter 10

CERTIFIED PEER SPECIALISTS

The use of Certified Peer Specialists (CPS) has been demonstrated to catalyze and enhance the transformation of day service programs. This is evidenced by the fact that pilot and second tier agencies who hired CPSs early in their transformation process developed vibrant peer cultures more quickly and fully. This is largely attributed to the following roles and attributes of CPS positions:

- The ability to function as models of recovery for staff and participants
- The ability to function as uniquely effective advocates for their peers
- The ability to function as full members of the program team
- The ability to contribute to the development of peer led groups
- The ability to initiate and carry out community integration activities
- The ability to assist in the development of Participant Leadership Councils.

It is expected that agencies approaching transformation will be authorized by DBH/MRS to hire one or more CPS staff and that these positions will be embedded as members of the day program team. This will allow for CPS personnel to be directly involved in development, implementation and ongoing service provision activities. Additional detail regarding the nature of CPS services is outlined in APPENDIX VI in the CPS job description template.

The following steps are required prior to hiring CPS staff:

1. Technical Assistance and supervisory training must be accessed from the Mental Health Association of Southeastern Pennsylvania (MHASP): Technical assistance will consist of a series of sessions with key members of agency Change Management Teams* and will focus on developing environmental readiness. Via this process, the recovery orientation of the agency and challenges to the implementation of CPS positions will be explored, as well as strategies to address these issues. Training regarding the role of CPS staff will also be provided as will training for personnel who will directly supervise CPSs.

   * Agency supervisor, human resources person, person in recovery and others as desired.

2. Development of job description: Prior to hiring, the agency must develop a CPS job description that is reviewed and approved by DBH.

Reporting: While the CPS staff working in day services will be embedded in the reimbursement rate (not billed separately), it is required that their general face-to-face activities be documented and reported as units of service to DBH/MRS (see Program Evaluation).

Additional information regarding CPS services can be found on the OMHSAS website (http://www.dpw.state.pa.us/About/OMHSAS/) in bulletin entitled Peer Support Services (issue date May 22, 2007) and in the power point overview of CPS services included in the appendix.

Chapter 11

SYSTEM RELATIONSHIPS

Relationship of Transformed Day Programs to the Rest of the System

Background and Context

The Day Programming Transformation process has endeavored to forge new ground in partnership and in service development that embodies a recovery spirit and that unflinchingly works to achieve the individualized recovery and life goals established by program participants. Within the transformed day programs, goals are now more broadly defined in relationship to multiple life domains and to achieving recovery in the community. The services we deliver are now changed, the locus of service delivery is substantially changed, and the roles of the persons we serve and of those delivering services have all been modified by this transformation effort. The new focus is to break out of the mold of being one aspect of a potentially complex array of services to being the primary focal point of behavioral health service delivery or the "recovery base" for the program participant. The partnership between recovering person and provider agency must broaden and deepen to fully take on the auspicious goals of recovery and community inclusion.

Expectations

As the recovery base for the person in recovery (PIR), the day program has the major responsibility for the provision of clinical and rehabilitative care. The treatment and rehabilitative team is responsible for:

- Developing treatment and rehabilitative recovery plans that are based upon the direction, preferences and goals of the person seeking recovery.
- Developing treatment and rehabilitative recovery plans that include, whenever desired and feasible, the family of origin or choice as the PIR defines it.
- Developing a proactive self management, self directed approach to behavioral health services including the utilization of mutual self help resources and mainstream community resources (e.g. employment, education, socialization, healthcare, etc).
- The delivery and integration of mental health and addictive disorder services.
- Monitoring data on service utilization provided by the Department of Behavioral Health in order to reduce service redundancy, to maintain an integrated wellness approach, and to maintain cost effectiveness.
- Tracking, monitoring, and celebrating the achievements of the PIR served.
- Maintaining continuity of care for the PIR, including coordination with CRCs and inpatient units.
- Educating residential providers regarding the transformation process and ensuring close coordination between day programs and housing services.

- Maintaining comprehensive records of service utilization of the PIR, regardless of where delivered in the system.
- Coordination and integration of care with physical health care providers and Case managers (when required).
- Coordination with community partners including spiritual and other mainstream resources to support the PIRs' recovery journey.

The recovery base program will share information with all partners and, with the PIR driving the process, develop and maintain a recovery plan with the necessary services and supports to facilitate recovery growth among program participants.

Chapter 12

LICENSURE AND CREDENTIALING

The following detail explains the types of licensure needed for transformed day services and the basic steps involved in securing the licenses.

A. Elements and Requirements:

- Both Outpatient and site-based Psychiatric Rehabilitation Service (PRS) licenses will be required for every transformed day program. Two licenses, rather than one, were determined to be necessary due to federal regulations restricting the bundling of services.

- The OMHSAS PRS Site-Based Standards are being used for both site-based and in-community rehabilitation service components of transformed day services (see appendix VII: OMHSAS PRS Standards). In collaboration with OMHSAS, via the granting of several waiver requests, it was determined that the site-based standards could also accommodate in-community program activity. This accommodation negated the need for providers to secure mobile PRS licenses in addition to outpatient and site-based PRS licenses. Please note that the use of PRS site-based licenses will not interfere with, or limit the provision of, services rendered in the community. Rather, it is expected that community integrated services will be a major focus of every day program.

B. Provider Expectations:

- Providers will meet with DBH representatives and staff from the OMHSAS regional office (Thomasina Bouknight and Scott Ashenfelter) once they begin the process of formally transforming their program. At this meeting, agencies will be given information detailing OMHSAS' expectations and instructions on preparing for the initial PRS licensure visit, including the following elements:

    - Letter of Support from DBH*
    - Certificate(s) of Occupancy (certificate for each program site)
    - Articles of Incorporation
    - Bureau of Equal Opportunity Letter (civil rights questionnaire sent directly to the Bureau of Equal Opportunity in Philadelphia)
    - Program Description
    - Policies and Procedures
    - Signed Staff Roster
    - Human Resource/Personnel Files for Staff (including relevant training documentation)

- Walkthrough of the Physical Plant
- Charts
  - For operational transformed programs, current and prior pre-conversion charts should be available for review.
  - For yet to be transformed programs, drafts of proposed charts and prior pre-conversion charts should be available for review.

* Annual letters of agreement issued by DBH will include detail concerning the approved number of direct Full Time Equivalent (FTE) personnel authorized to staff designated day program(s). Proposed changes in the number of FTEs must be pre-approved by DBH. Unapproved staffing increases or decreases may result in the revocation of current letters of support and/or the denial of future letters. Note that program capacity is correlated with shift-based staffing ratios that are set at minimum of 1:10 for combined PRS site-based and in-community services (see attached OMHSAS PRS waiver correspondence).

- In order to apply for a PRS license and to schedule an initial site visit, providers must do the following:

  - Complete a OMHSAS Supplemental Service Application (obtain from DPW website or from CBH provider rep), a service description and civil rights compliance application and submit these to CBH (attention Dana Morse) and to the OMHSAS regional office (attention Scott Ashenfelter)

- The CBH credentialing process will occur simultaneously with the Regional OMHSAS PRS site visit. No changes to CBH credentialing expectations are anticipated at this time.

- Once providers have received their new licenses, they are required to formally retire their PHP license via correspondence to OMHSAS (cc'd to Sean Gallagher at CBH)**.** At that point, providers will cease billing CBH for PHP services and begin to utilize reinvestment or other dollars identified by DBH (see Financing section). DBH will identify a reinvestment time period for each agency.

- Prior to obtaining a PRS site-based license, providers must make detailed preparations to radically change their day program structures and scheduling, and submit a plan to DBH describing how they meet the readiness criteria that must be approved prior to DBH authorization of the reinvestment funded transition period. This period will afford program participants and personnel the opportunity to experiment with new roles and activities without the need to comply with licensure requirements. Primary emphasis at this stage should be placed on the introduction of supports rendered in community settings that serve to engage and energize both recovering persons and program staff.

Chapter 13

ADMISSION CRITERIA

Historically, a substantial number of persons in traditional day programs have utilized these services for over 3 years; a smaller but not insignificant number have attended these programs for a decade or more. These programs have been seen as a long term resource by many of those seeking or providing these services. Although great variations exist, successful graduation from these programs into more normative roles in society has not typically been a primary focus. Furthermore, on a county wide basis the number of persons attending Partial Hospital Programs (PHPs) has decreased over the last decade. Such programs appear to have limited appeal to the large number of young adults entering the mental health service system annually. Many young persons have articulated the desire to avoid PHPs due to their perceived association with very serious disability and the absence of services that support and encourage normative, community-based roles (school, jobs, etc.). Consequently, many individuals needing comprehensive services remain unserved rather than opting to participate in the limited day service models that have been historically available. From a business standpoint, attendance has been declining and new populations have not been typically engaged into this service approach.

The new, flexible, recovery focused approach to Day Services is expected to attract more people to transformed programs. Over time it is projected that the numbers of persons served will increase due to the shorter service stays and an emphasis on graduation for persons who are able to achieve significant levels of independence.

Initial providers were encouraged to consider targeting their services to particular subpopulations such as persons with co-occurring mental retardation, co-occurring substance abuse, aging out youth, older adults, etc. The intention is to gradually move from a generic PHP model to a cluster of transformed programs that employ more evidence based approaches and demonstrate population specific expertise. There is also a desire to ensure that individuals who have repeatedly accessed psychiatric inpatient or Crisis Response Centers (CRCs) are afforded ready access to transformed day services. Consequently, outcome measures will be developed to encourage admissions involving heavy users of hospital and crisis services.

The admission process and criteria governing access to transformed day programs are intended to facilitate rapid entry into these services for a broadly defined population. Note that providers will be required to submit their recommended admission criteria and proposed program specialization to the Department of Behavioral Health (DBH) for review, feedback and approval.

The following summary details the criteria and process involved in admitting individuals to transformed day services:

A. Elements and Requirements:

Admission Criteria
Service candidates must meet the following basic criteria in order to be eligible for admission and ongoing service:

Note: The following criteria are consistent with the Psychiatric Rehabilitation Services (PRS) Standards

- 18 years of age or older
- Diagnosis: schizophrenia, major mood disorder, psychotic disorder NOS, schizoaffective disorder or borderline personality disorder. (Providers may request exceptions for other diagnoses based on justification)
- Expressed desire to participate in program services. Note this does not require that candidates indicate interest in all program components. E.g. persons only interested in community-based services should be granted admission. Flexibility in tailoring services to individualized preferences suggests that this criterion should exclude very few individuals.

Furthermore providers will be required to submit plans to DBH indicating their intentions to market their services to the populations they aspire to serve. These plans should include detail regarding linkages with other service systems and providers. e.g. inpatient units, Extended Acute Care units, Norristown State Hospital, Philadelphia Prison System, schools, etc). Providers are encouraged to market to a broader range of subpopulations.

No Reject Policy
Providers will be required to accept any and all service candidates referred by DBH/Community Behavioral Health (CBH) for admission to transformed day programs. Agencies are encouraged to accept candidates with a wide range of needs including people with extensive histories of inpatient treatment and crisis service utilization. If it becomes apparent that persons with challenging needs are not being afforded sufficient access, DBH will consider other measures to ensure that these individuals are granted access.

Crisis Prevention/Intervention Plans
The process of crisis planning and prevention should begin at the point of admission and continue throughout the period of program participation.

Additional Admission Considerations
In order to meet the needs of recovering persons, especially those being discharged from hospitals, all transforming day programs are required to develop streamlined and expeditious intake and admission policies that allow for same day program entry. DBH also encourages the development of strong linkages with hospitals. Since services can be delivered at other sites (“in community”), integrating intake services within other milieus may be feasible.

Chapter 14

FINANCIAL PROCESS

I. PURPOSE

The purpose of this section is to provide agencies participating in the day program initiative with guidelines for completion and submission of budgets and invoices. This section also explains the process that will determine the payment methodology used to reimburse agencies participating in this initiative.

The information presented in this section is intended to provide a procedure to assist The Department of Behavioral Health (DBH) in transforming the current program funded reporting and payment system to a rate setting reporting and funding system.

II. BUDGET

The following schedules must be included in the budget proposal associated with the conversion of Mental Health site based day programs to the recovery based day programs.

A. Budget Narrative

B. Transformation – Crosswalk Schedule

The amount of day transformation expenses reported on this schedule should be cost neutral to the traditional day program expenses reported on this schedule

C. Start – Up, Annual, and Operational budget submissions must include the following schedules:

a. Expenditure Summary
b. Personnel Budget Schedule
c. Miscellaneous Item Detail Schedule
d. Budget subsidiary Schedule

The Start – Up budget must include projected expenses associated with the conversion of the existing day program to the transformed day program. The Start – Up period is a specific amount of time required to make purchases and renovations to the site before the actual operation of the program.

This budget must all include Start – Up expenses associated with the hiring of the Certified Peer Specialist.

The Annual budget must include projected Personnel, Operational, and Administrative

expenses for a twelve (12) month period. This budget must include the annual expenses associated with the hiring of a Certified Peer Specialist.

The Operational budget must include projected Personnel, Operational, and Administrative expenses for a specific period of time (3 months, 6 months, etc.) .The Operational budget should be based on the Annual budget. This budget must include the Operational expenses associated with the hiring of the Certified Peer Specialist.

In preparing the Day Program Transformation Budget agencies should set aside funds associated with Client Recreation activities.

III. INVOICING

A. The actual cost associated with the operation of the transformed day program must be reported on the following invoice schedules on both a monthly and quarterly reporting period.

   a. Expenditure Summary
   b. Personnel Budget Schedule
   c. Miscellaneous Item Detail Schedule
   d. Budget Subsidiary Schedule

   The day program monthly invoices are to include non-cumulative expenses for a specific period. Quarterly invoice submissions are to be year – to - date cumulative expenses.

B. Start – Up and Operational cost incurred in the providing of services to individuals in the transformed day programs must include the cost associated with the hiring of the Certified Peer Specialist.

C. In addition to the monthly and quarterly invoice submissions the expenses associated with the day program transformation program must be reported on the DBH fiscal year end invoice submission.

IV. PAYMENT

This section deals with the various payment options currently available to DBH in reimbursing agencies for expenses incurred in the day program transformation

A. CBH Reinvestment funding based on the monthly expenditures submitted by agencies to DBH, in order to be reimbursed for Start – Up, Certified Peer Specialist, and Operational cost. The Reinvestment funding is for a specified period of time.

B. CBH has advanced agencies one-twelfth (1/12) of their approved allocation each month for a specific period of time. The monthly invoices will be reviewed by DBH,

if any agencies are invoicing expenses that are unspent by more than five percent (5%) then the succeeding month's advance payments must be adjusted by CBH.

C. The current payment procedures mentioned in sections a and b above are being implemented by DBH as an intermediate step in converting to a approved rate for the day programs.

D. DBH will maintain a historical set aside allocation to reimburse expenses incurred by agencies providing services to non-MA and/or zero liability individuals.

Chapter 15

PROVIDER PERSPECTIVES

Below are various comments from the piloted provider agencies who went through the day transformation process and who are currently functioning and operating under more recovery-oriented services. The comments that were received were grouped in categories (Preparations for Transformation, Things to Consider, Provider's Role, Think In-Community, Transportation, & Encourage Inclusion). The categories are simply to promote some clarity of the comments that were given. These are comments that are directed toward those programs seeking to transform in hopes that they will provide some guidance, assistance, and an overall less complicated path to the era of recovery.

Preparations for Transformation

- Begin by initially adding groups centered around discussions of "what recovery is", the pillars, etc. As personnel are trained, add more EBP groups.
- Begin having regular meetings of Peer Government to plan for changes to curricula, based on member's input.
- Start out by scheduling daily opportunities for small groups (up to 5 individuals) to go out into the community. Outings should be more recreational and fun in the beginning to increase enthusiasm for leaving the building.
- Have a project manager who does not have duties in your current PHP.
- Set up a management team to plan/implement all aspects of the program, based on recommendations from the stakeholder group.
- Visit other programs and consider hiring consultants.
- Begin to adjust your policy and planning manuals in advance of licensing.
- Try to have protocols (practices, forms) decided prior to transformation; this will make it easier on staff.
- Hire your CPS staff at least one month prior to the transformation start date. They can help the process by beginning to establish relationships and teach recovery principles.
- Provide ample opportunities for ALL agency staff and Admin to have training and orientation to the concepts of recovery.
- Set clear/realistic deadlines for the transformation/implementation process, including, time for possible disruptions (construction, staff turnover, etc).
- It has been suggested that there should be a great amount of time given to staff to plan for the changes. For example, the switch from site-based to community-based activity should be rolled-out in steps with specified timeframes. For example, staff should be exposed to community or field work trainings.
- Before starting any changes, get feedback from all levels, staff and participants. Staff should be given the opportunity to provide feedback, and it should be considered.
- Address the extensive training needs of personnel prior to implementation, including topics such as housing, case management, and physical environment.

- Residential supports should have been considered and addressed in tandem with the day program transformation.
- Give participants plenty of time to process the program changes and transitions. Always consider the impact of programmatic changes on participants.

Things to Consider

- Consider reducing site based hours quickly in order to make time and allow the flexibility needed to implement community based activities. Letting go of the highly structured and predictable PHP schedule and program components hastens the practical day to day change process. Decreasing, based upon participant choice and interests, on-site hours and programming sets the stage for the program to begin to grow into the community. This is no longer a 6 hour per day program.
- Consider changing your decor to reflect the concept of recovery: less "clinical" looking furniture; art chosen by the members; consider having members do a mural
- You may want to open up some space for community areas; rooms that are not "group" rooms, for socializing, etc. dedicate space to the consumer government.
- Get wireless internet and some laptops
- Improve your technology, so that teaching WRAP and Evidenced Based Practices is easier: get a projector, laptop, etc.
- Anticipate problems with some residential resources and MR providers who expect people in recovery to be offsite for set prescribed hours as they have been historically. Change management requires increased communication within the agency and with others outside of your agency. This can be an opportunity for educating other providers and systems about Recovery, but can create some conflict.
- It's important for everyone to be aware that different populations present different challenges in terms of recovery planning and in-community skill training and practice. Starting where the person is and using their desires and goals must be the springboard from which change begins. One size does not fit all.
- Communication is very crucial when a transformation is initiated and important throughout the change process.
- Keep in mind that some participants don't want to or are not able to go into the community.
- Some participants want to come to program five days a week.

The Provider's Role

- Having a recovery focus does not negate good clinical skills. A recovery focus enhances good clinical skills.

- For every role, (staff, director, peer specialist, supervisor) it is important to have ways that you replenish yourself. In facing the changes and challenges associated with the transformation it is important that you take care of your self.
- Energy and excitement is a key motivator in the early stages of the process.
- The new choice directed, more fluid environment requires a different and closer supervisory role. I now often meet with my staff for a brief 15 minute check-in every day or at least three times a week. The new program has more of a CTT feel to it. Logistics are more complicated with the great flexibility the in community piece offers.
- With a newer population beginning to come in coupled with Social security changes, much work has to be done regarding benefits.
- All levels of the organization must show a strong commitment for the change process (MH Director and Executive Director set the tone re intention, importance and urgency). This sounds rather straightforward but the support must be strong as this is a major change effort.
- Take every opportunity at the Executive level to show line and supervisory staff they are valuable – we gave gift cards and verbal and written praise.
- Little successes add up. Look for repeated small positive steps and lavish genuine praise for these successes.
- Pay attention to all "personal" goals such as educational and employment desires.
- Helping recovering people enroll and attend educational classes gives them the self confidence to take on other goals.
- Allow recovering people numerous chances at whatever they are attempting. Our patience and perseverance allows them to develop patience with themselves – and this allows them to try again without shame and with less fear of failure.
- Provide clear definitions of what is expected of staff, and stay consistent of the expectations.

Think In-Community…

- The community challenge is an interesting one. Rather than instituting a computer learning lab onsite we looked around for a place to host the lab in the community and identified a branch of the library. We encourage providers to always think, can we do this in the community. Having planned and scheduled or choice based activities in the community helps to decrease the internally held stigma of folks in the program, of staff and hopefully eventually of people in the community.
- The opportunity for a change of venue – from onsite to in community – helps us also to keep asking ourselves the question: what would be interesting to people in the program, and this leads us to ask them for their ideas and desires. But this does not give staff a passive role, but an active creative one, helping people see their choices and helping them perceive opportunity and interest.
- Stronger effort to promote community inclusion, and provide necessary supports to do so.
- Introduce (re-introduce) yourself and the agency to the community. By doing this you may want to identify what community resources would be valuable to your

agency but also provide information where your agency can benefit the community as well.

- Educate community resources on your population and what the City of Philadelphia is attempting to do with transforming your agency. I have found that many community centers have preconceived notions and stereotypes about our population where they believe our individuals pose a risk to the community.
- Visit local libraries and community centers to discuss times that may be available to benefit your population.
- Visit local Personal Care Homes, CRRs, shelters, and families to discuss what the transformation of the programs will mean to them.
- Invite the community, family members, external supports to your consumers to an open house to describe exactly what your goal and objectives are in your transition.
- For individuals who are hesitant in re-entering the community:
    - Identify participants that may be a little hesitant to going out in the community.
    - Have staff work one on one in an attempt to alleviate some of their anxiety.
    - Start with walks in the neighborhood or going to a donut shop/café to do a session.
    - Offer fun activities in group settings (bowling, skating, movies, restaurants, etc.).
    - Identify activities in the community that may assist them in their Recovery Goals (visiting places they may want to work or volunteer).

Transportation

- Be prepared for complications re: transportation, particularly for individuals reliant on MATP vans. Work with individuals to commit to a schedule, and then do Logisticare Standing Orders to reflect this commitment. Be sure to be in contact with any residential provider to inform them of the plans.
- Begin to spend a good amount of time with travel training; you may need to include a stock of tokens in your budget.
- Working with Logisticare has been an incredible challenge. Initially they agreed at a public meeting to give transpasses to everyone who is scheduled for three days a week, stating this costs the same as tokens. However at a subsequent meeting they indicated they have not said that and reneged on what appeared to be a great partnership. Transformation requires transportation! Now one of our programs continues to get a monthly transpass for 3 days a week, while another does not. Logisticare has incredible inconsistencies.
- Daily passes limit in community options for program participants especially when they require transfers to get into the agency and home again.
- We recommend other providers obtain free trainer and trainee transpasses from Septa. Training people in recovery in transportation skills is an essential practice

for opening up the community to them, and to elevating their sense of self confidence and competence!

Encourage Inclusion

- We didn't have a pre-determined model and focused on building the program based upon the needs and desires of program participants.
- We recommend you include staff of all levels and many people in recovery in each and every step – especially the initial ones – of the change process.
- We talked to everyone and started with a positive recovery oriented focus asking: what do you like most about the program as it is. Here we discovered the most frequent answer was "therapy". None of the models we had heard from DBH emphasized therapy although the RFTP did. Hearing from the participants made it clear this was important to them.
- We asked people in recovery to tell us freely what they did not like and what they wanted to be different – and in what way.
- We also asked what needs and preferences do you have that are not being met and we heard very clearly that program participants wanted much more individual time and attention. Planning our program to be able to address this desire has clearly paid off in recovery gains and relationship building. This is really a core idea in our estimation.
- We initially met with families both in the day and evening to ask them similar questions and to let them know that as we changed the program their needs and desires were important. We also educated them about some new directions and about recovery from mental illness.
- We also talked to recovering people who have not historically attended our partial program (many TCM participants) and asked them their perceptions of the program from the outside and what they had felt would not work for them. We also asked them what type of services in a day program would meet their needs and excite them.
- Absolutely all program participants were in at least one 30 minute focus group.
- We quickly encouraged program participants to join CSP and to attend any and all trainings that they could access. We knew we would lose money but made this commitment. You have to invest in the future.
- We immediately went to work on, and took very seriously, a recovering person stakeholder group. We held elections to get representatives for our "Transition Team".
- We reimbursed recovering people for transportation to CSP meetings and all trainings. We let them know that their development and opportunities were important to us and vital to the change process. We looked for trainings and opportunities for them.
- We purchased appointment books and office supplies for recovering people who were stepping into leadership roles. We wanted to show them we valued them in a direct and tangible manner.

- We built in time when recovering people went to meetings and trainings for them to report on what they learned to the Transition team and the community. Again, keep thinking about how to elevate their status. Recovery and positive self regard comes not just directly from service delivery structures, but from the role and status the program confers upon participants at every opportunity.
- We changed long standing set appointments i.e. with physicians, to allow Recovering people the time to go to trainings, meetings and opportunities. The entire schedule started out becoming much more flexible and this continued as we built choice more directly into every interaction.
- We made the commitment to staff to allow and encourage attendance at trainings even when that could have an impact on billings
- Some experienced/older PHP staffs were not interested in going into the community, but once we eliminated daily notes there was a major positive reaction to the change process.
- Certified Peer Specialists are an extremely valuable resource for engaging recovering persons, for engendering trust and for developing deeper sharing of very personal issues.
- Recovering people often open up more quickly and more deeply to someone who has been there. They feel less embarrassment and consequently a greater willingness to accept themselves and to try new behaviors.
- Look for opportunities to engage peer culture i.e. allowing peers to decide how to use canteen profits and address CST issues. Whenever you see an opportunity for the stakeholder group, hold yourself back from your historic tendency to make decisions and instead ask them for direction. Asking them does not diminish staff roles. Staff should think about their roles and actions in a different fashion. They are facilitating the change process of individuals and the community. Their job is to encourage and empower.
- The Member Council is the most important tool for transformation and change we have used. It has helped to guide us. It allows a forum for staff to "give over" decisions to program participants and to make real the shift in power.
- Programs and target populations vary greatly and their transformation will as well. Try to listen to each group as well as to individuals' voices and preferences. Different strategies work for different groups.
- Early development of a Participant Council assists in the transformation process, and serves as a mechanism to provide feedback, implement strategies, & give voice to consumer needs. Council should include a representative group from the overall community, i.e. men, women, various age groups.

Chapter 16

DISCHARGE AND POSITIVE PROGRAM OUTCOMES

BACKGROUND AND CONTEXT:

Traditionally, maintenance Partial Hospitalization Programs (PHPs) did not emphasize community integration, recovery or successful program graduation. Many participants stayed in these programs over long periods of time. Long-term lengths of stay in PHPs were frequently presumed to indicate sustained stability and related positive outcomes such as reduced inpatient utilization. In contrast, transformed day program goals are more broadly defined in relationship to multiple life domains pertaining to the achievement of recovery in the community and less upon treatment and behavioral goals. Emphasis is now placed upon the utilization of mainstream resources (social, recreational, employment, educational, etc); individualized community based coaching and skill supervision; and the concomitant learning and practice of new skills in community environments. Reimbursement mechanisms have also changed to permit flexibility with regard to the pursuit of individuals' recovery goals. Providers are no longer required to enforce attendance norms in order to maximize their revenues.

These new realities have been applied to the development of the following key principles:

Principles:

- Over time as individualized recovery plans are effectively implemented, it is assumed that many individuals will move forward in their recovery (to varying extents).

- Transitions to step-down or alumni status must be planned in coordination with participants and all relevant stakeholders including recovering persons, family members, recovery coaches, psychiatrists, etc.

- Structures are needed to reinforce the pursuit and attainment of recovery goals and to celebrate and reward these accomplishments.

- It is not assumed that everyone's recovery process will eliminate the need for on-going professional support nor that graduation should be encouraged when there is a need for substantial ongoing assistance.

- Transformed programs will target a broad range of people with high needs for behavioral health services, including significant numbers of individuals who previously would not have desired PHP services. Emphasis on graduation and positive program outcomes should not be applied such that it inadvertently limits access to those with very challenging needs.

- It is assumed that even individuals with substantial behavioral health challenges can and will graduate. The programmatic norm should be that lives for all people including persons with serious mental illness should be based upon real world norms. Therefore program graduation should be a clear goal for most participants.

- Despite the strong belief in the ability of many people to recover substantially and to dramatically expand their lives and social roles in the community, it is not intended that individuals be encouraged to consider pursuing program graduation unless they are ready and willing to do so. While a recovery vision maintains hope for substantial progress for all, challenges and success vary considerably.

- The progressive achievement of recovery goals will culminate in many individuals having fuller lives in their communities and, as a result, less interest in maintaining program participation. This decreased desire and need for program participation might take varying forms: e.g.

    - Some participants may not need or choose any continued programmatic involvement.
    - Some participants may desire limited alumni services and supports
    - Some participants may need and desire ongoing services in excess of alumni supports
    - Some participants may desire less program involvement, yet not meet graduation criteria

Proposed Guidelines for Provider Established Graduation Discharge Policies

Providers have suggested a variety of options that are currently being considered with regard to the number of service hours/units that should be allotted for persons with step-down or alumni status. Details concerning this issue will be clarified at a later date. The period of time that alumni may continue to access program resources is also under consideration.

- Programs should clearly establish graduation as a celebrated and reinforced program goal.
- Establishing an independent and interdependent life in the community that each consumer defines and desires is an overarching program goal. Recovery is about living the life one chooses in mainstream environments.
- Programs are asked to define a step down status pre-graduation that reflects a movement away from higher levels of staff assisted services, plus the accomplishment of major elements of the individualized Recovery Plan. Step down status will be limited to a defined number of hours per month. Providers have suggested a variety of options that are currently being considered with regard to the number of service hours/units that should be allotted for persons with step-down status. Details concerning this issue will be clarified at a later date.
- Graduation will occur prior to the provision of alumni services

- Alumni services will be limited to a defined number of hours per month. and emphasize PIR self help including ongoing services delivered by Certified Peer Specialists. All program graduates will be eligible for alumni services and encouraged to participate in them. Providers have suggested a number of options that are currently being considered with regard to the number of service hours/units that should be allotted for persons with alumni status and the . Details concerning this issue will be clarified at a later date. The period of time that alumni may continue to access program resources is also under consideration.
- All alumni are entitled to expedited program reentry when needed and desired.
- Graduation should be individualized and based largely but not exclusively upon individualized goal setting. Clear graduation goals should be established in each recovery plan within 6 months of admission. Clear unambiguous goals assist in goal achievement. (These goals will of course be modified over time).
- Graduation requires the development of and implementation of a personal self-directed life management plan (such as a WRAP)
- Graduation should occur when a PIR asserts she/he has established the "recovery capital" or personal resources and supports to maintain their recovery in the community with limited professional assistance. The attainment of this recovery capital should be reflected in the recovery planning process and documentation.
- The self directed life management plan should encourage the utilization of self help resources, personal support system development and utilization of personally selected mainstream resources and opportunities.
- CPS personnel are a mechanism for maintaining ongoing alumni supports and a component of their time should be dedicated to that function.

In order for graduation rates to be compared across programs, some uniformity of definition across programs is required.

Proposed Standardized Criteria:

- Participant has expressed a desire to graduate from the program
- No more than 1 psychiatric inpatient or CRC episode for at least 4 consecutive months
- Documented attainment of primary recovery plan goals. Achievements related to these goals must be maintained for at least 3 consecutive months
- Completion and implementation of a self management plan (WRAP or alternative) which includes a crisis plan, a strategy for self care and support, and, if desired, an Advance Directives document.
- Completion of an Advance Directive, Crisis Plan, Wellness Recovery Action Plan (WRAP) or alternative self management plan, including a strategy for help and wellness support
- A plan is in place to attend to physical health including regular medical and dental care
- Participant has an understanding of the role medication plays in his/her continuing recovery, is appropriately utilizing medication, and has arrangements in place to continue obtaining prescribed medication upon discharge.

- Development of a post graduation support plan, including information about re-entry to the program and one or more of the following:
  - Outpatient treatment appointments
  - Follow-up support from a day program Certified Peer Specialist
  - Participation in a peer self help group
  - Participation in an ongoing WRAP support group
  - Participation in a day program alumni group

ATTACHMENTS

FAMILY RESOURCE NETWORK
RESOURCE INFORMATION
(APPENDIX I)

The Family Resource Network (FRN) is a coalition of programs who support the principles of recovery by providing family consultation, family workshops, and family support groups.

FRN is also involved in family inclusion by promoting its members to behavioral health providers, to plan and discuss topics that best address the needs of family education and support, formulate model standards for family involvement, and take a leadership role in governmental & agency meetings.

The members of the Family Resource Network are:

- NAMI North Philadelphia: Delores Jackson, 215/228-7214
- NAMI Northeast Philadelphia: Frank Eichhorn & Judy Long, 215/342-9553
- Northwest Philadelphia: Thelma Freeny, 215/549-8468 & Gloria Worthy, 215/224-6307
- West Philadelphia Educational Support Group: Rea York, 215/586-5955
- Nami Grupo de Apoyo (for Spanish speaking families): Rea York, 215/586-5955
- Psychoeducational Program: Melvin Dennis, 215/742-7806 & Rita Ferry, 215/ 742-7816
- Training & Education Center: Edie Mannion, 215/751-1800
- Family Support Specialist: Angela Smith, 215/546-0300, ext 2357

For further information contact the Family Resource Network at 215/546-0300 ext. 3259.

Family Friendly Release of Information Form

ABC RECOVERY PROGRAM

Authorization to Release Confidential Information to Family/Significant Others

Effective for one year from _____ to _____

NAME:_____ DOB:_____ SS# XXX-XXX-___

I hereby request and authorize ABC Recovery Program to **verbally** release information regarding myself to the individuals listed below. I understand that the purpose of this release is to provide communication between this program, myself, and the person listed below. This information exchange will provide an aid for my recovery and for my family's support. The information exchange will include the effective date of this authorization.

I hereby request and authorize you to release the information indicated below to the following individual:

Name:
_____
__

Address:
_____

City/State:
_____Zip:_____
_

Day Phone: _____ Evening/Cell Phone:_____

You have my permission to verbally discuss the following information:

- ☐ Name of treatment/recovery program(s)
- ☐ Name of Case manager
- ☐ Name of therapist/recovery coach
- ☐ Diagnosis or diagnoses
- ☐ Service/recovery plan
- ☐ Schedule of activities or appointments
- ☐ Progress or obstacles to progress
- ☐ Discharge or transition plan
- ☐ Medications/side effects (Medications to treat HIV/AIDS are excluded from list of disclosed medications.)
- ☐

Other_____
_____

☐ You have my permission to invite the above-named individual to participate in treatment team or recovery planning meetings.

This information has been disclosed to you from records whose confidentiality is protected by federal and state law. Federal regulations (42CFR Part2), PA (Chapter 255.5, and Title 55 Chapter 5100 and 6400) prohibits you from making any further disclosure, including Drug and Alcohol information, without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for releasing medical or other information is NOT sufficient for this

purpose. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer will be protected by this rule.

I have been informed of my rights to 1) Revoke consent at any time by written request. This authorization is subject to revocation at any time, except to the extent that action has been taken to reliance on the authorization;
2) Inspect and receive a copy of the material to be verbally released; 3) Request restrictions on how my health information is used and disclosed; and 4) Receive a copy of the authorization and the Notice of Privacy Practices.
This form has been fully explained and I certify that I understand its contents, and that ABC Recovery Program may not condition services on obtaining this consent/authorization from me.

_____ _____

Participant's Signature or Oral Consent When Unable to Sign Date

_____ _____

Signature of Authorized Person in lieu of Participant Date

☐ Power of Attorney ☐ Guardianship Order

_____ _____

Witness Signature Date Oral Consent Witness Signature Date

☐ Accepted ☐ Declined

QUARTERLY STATUS REPORT
(APPENDIX II)

FORMAT PENDING

PHILADELPHIA DBH DAY SYSTEM TRANSFORMATION

LESSONS LEARNED & GUIDANCE TO START-UPS
DECEMBER 2007

(APPENDIX III)

This document provides a summary of lessons learned culled from work accomplished during the first year of day system transformation of traditional partial hospitals to day services and supports. These transformed programs are recovery oriented with an emphasis on **recovery planning**, **community inclusion, peer culture/support and leadership and family inclusion**. These transformed programs provide a combination of treatment, rehabilitation, mobile and site based services. The contribution to this learning was the result of a **partnership** between DBH and Elwyn, PATH, Horizon House, Community Council, JEVS, COHMAR and the Wedge. This document is meant to provide guidance to startups that will follow.

The summary of findings below represents trends present in most if not all of the transformations of these seven programs.

Vision, Change Management and the Guiding Coalition

1. For successful transformation to occur there must be a sense of urgency regarding the change**.** Agencies who think they "already do it" have demonstrated little motivation for change. Agencies who acknowledge the need for change have moved quickly in the direction of recovery planning, community exposure leading to community inclusion and development of a vibrant peer culture. They are working on finding new paths to engaging and connecting with families. Such urgency can be both internally applied by the program itself and/or externally applied by DBH. Programs who have joined with DBH in partnering around this sense of urgency and have received professional support through consultation, have garnered significant gains from the relationship.

2. The program's vision of recovery should be clear and bold. The vision, in order to be activated, must be translated into an implementation plan.

3. Agencies who have formed a powerful guiding coalition (Change Management Team or CMT) with representation from all stakeholder groups have witnessed significant and rapid gains in their transformational efforts.

4. The guiding coalition or CMT must have the authority and accountability to make decisions in guiding & facilitating the transformation. Support from

executive management, demonstrated concretely and publicly, is critical to the functioning of this group.

5. The CMT Chair has to have access to the CEO or administrative lead in order to allow for swift adjustments and self-correction to the project.

6. When the guiding coalition has recovery champions as part of its membership the enthusiasm is contagious and creates momentum for the continuous change necessary for true transformation.

7. This coalition must constantly communicate the vision to all stakeholders with variety and persistence.

8. The guiding coalition needs to identify, acknowledge and reinforce early successes as demonstrated for example, by "recovery" shifts in staff/consumer relationships as well as member's movement in recovery.

9. While the guiding coalition takes the lead on the above, they create opportunities where staff and participants are quickly empowered to take on the vision and act in new ways, identify opportunities to act on new thinking, explore, etc.

10. Successful partial transformations to date identify obstacles to change, take a non-defensive stance and create strategies to eliminate or minimize their effect.

11. Successful transforming programs have demonstrated a willingness to take risks**.** DBH has encouraged start-ups to consider new practices that stretch both organizational and professional practice. Energized learners among programs have taken advantage of this opportunity.

12. In both conceptual and practical terms, the CMT must pay attention to the pace of change, balancing the urgency to change with other competing conditions.

13. Programs that are moving forward with transformation have paid close attention to sharing information with the grass roots level of the program and with all levels above the program. This information sharing moves in a 360 degree feedback loop so that the effort can be self-corrected quickly. Buy-in has to move top-down and bottom-up.

14. Successful agencies are engaging in a continuous change process that is self-correcting and continually evolving and learning.

15. Agencies with complex bureaucratic cultures tend to be less nimble to external and internal demands to shift practice. Agencies that can acknowledge this and develop and implement methods to change the culture are moving forward with transformation.

16. Peer support within agencies and within DBH has proven to be a powerful force in transformation. Learning from each other has helped to identify strategies for success.

17. The transformational change management literature has contributed to leadership development and strategic thinking.

18. The involvement of program participants at every phase of the transformation has proven to be a critical component to progress and success.

19. Both DBH and program participants are expressing the need for change and are more than willing to give a helping hand. Resistance to this change to date has proven to only stall transformational efforts. A transformational momentum is growing within the city's behavioral health community.

20. Specialty "guilds" within programs (for some, medical staff, for others, therapists, for others, recovery coaches, or similar) may push back to protect their roles and status - what they "do" and "don't do"; these issues need to be addressed early and often and where significant shifts are expected, those changes should be clearly stated and supported, ideally from program leadership.

21. Prioritization of effort is critical to both conserve resources and to effect initial gains.

Leadership Everywhere

1. Executive leadership buy-in is critical. The more public and sincere that is demonstrated the better. Consultants and the CMT should try to build an alliance with at least one to three internal leadership champions and use these relationships strategically to move the project forward.

2. Leadership behaviors that are consistent with the recovery values of partnership and creativity, should be encouraged. This would include the action of staff, consumer champions, family and community participants and early adopters at all levels.

3. Early successes need to be shared broadly and form the basis for follow-on efforts. Initial resistance, fear of change, etc, should not discourage agency leadership, staff and consultants. Identify staff acquainted with and interested

in the transformation of practice. Support, reinforce and celebrate the work of these early adopters.

4. The need for knowledgeable and committed leaders cannot be underestimated. The concept of collaboration being employed by DBH is cutting edge management practice and unusual for us all. Providers should believe that asking for help, being confused and/or afraid of chaos is part of the process and in fact will lead to learning! In other words having the support and confidence to say, "help" is adaptive behavior for both DBH and providers.

5. The success of the transformation rests on the shoulders of the program leaders who engage in accountability-driven, supervisory practice focusing on supporting the development of relationships at all levels but especially between staff and people in recovery.

6. Collaboration with psychiatrists and other medical staff should begin during the early planning stages of program transformation in order for the effort to be comprehensive and successful.

Peer Culture

1. Prioritize the development of peer culture. The faster peer support at all levels can be ignited, the faster the transformation will be ignited.

2. Hire CPS staff as early in the process as possible. They are catalysts for the transformation. The development of CPS roles and for that matter all new roles in the program cannot be finalized or realized within job descriptions but by day to day practice, relationship development, direct communication and patience.

3. Peer-lead groups, begun early in the process, have contributed to inspiring program participants to aspire for more in their lives.

4. In several cases, practical steps at supporting growth of the peer culture have accelerated peer adaptation to the new program faster than the staff adaptation. The CMT and peer leadership must manage this imbalance in the early months of the program start-up.

Recovery Planning

1. Creating a simple recovery planning method has proven to spark interest in deeper staff/participant relationships, movement outside the program, and has elevated consumer driven conversation and plans. Recovery planning has

helped to create early consumer successes as well as allowing for the examination of traditional roles and the beginning of new dialogues.

2. When possible recovery planning conversations should be done in the community as this has been shown to energize the conversation and shift it in ways that are surprising to staff and to program participants.

3. As soon as possible, link recovery planning to community exposure from a walk around the block to larger cultural activities. As participants and staff learn, connect individualized community integration activities directly to the recovery plan.

4. In the most successful transformations the recovery planning meetings are used as opportunities for the development of a process that allows for the transfer of knowledge among staff with different roles and levels of training. These meetings are best done with all members of the team (including CPS staff) present so that all can learn from one other.

Friends, Family and Networks of Support Inclusion

1. It is important to recognize that family engagement within traditional mental health programs left families confused, marginalized, excluded or afraid. Inclusion of family is a delicate relational process, which requires time and respect. Educating staff in how they can engage families is critical. Efforts in the first year to engage families are best directed toward social events, low demand settings and safe opportunities for family/staff and people in recovery.

Education

1. Re-examination of the educational aspect of the program must be undertaken. Educational services must be driven by participant preference and need. Inclusion of peer led groups early on, will support this transformation.

2. Traditional content of partial groups/educational activities needs to be examined in light of aspirations and recovery plans of participants. These should guide the selection of site based and off-site educational activities.

Role of Consultants and Learning Opportunities

1. Outside consultation can provide energy, vision, perspective and specialized skill sets.

2. Consultants with a recovery orientation, passion, vision, and expertise have proven to be instrumental to the startups to date. Consultants utilize every contact as an opportunity to build relationships, teach, and identify solutions to barriers.

3. Consultants have been instrumental in assisting Change Management Teams and staff/participants in designing methods to track their transformation, documenting progress, meeting management and determining new delegation practices (use of peers, participants, other resources, etc.).

4. Consultants have been instrumental in assisting programs in assessing reluctance, resistances and impasse. Consultants can assist in normalizing the change process and grounding this process for staff, etc. In addition they can help in creating strategies for addressing resistance in a meaningful and educational way.

5. DBH in partnership with providers intends to support each and every site in having and providing the content necessary to make these transformed programs, authentic centers for learning and competency building. These programs should afford participants enough support, education and community exposure that participants become able to be independent of the program itself, to the best of each consumer's ability and aspiration.

Infrastructure

1. Create a budget that supports the varieties of transformational tasks. (see below)

2. Implementation plans have proven to be helpful to the CMT in managing the complex tasks needing to be addressed. Identify benchmarks for progress both in the near term (1-3 months) and for the mid-term, 3-6 months. Maintain and update this plan and continuously chronicle progress.

3. The continuation of the traditional partial hospital daily schedule may be the largest barrier to igniting the transformation. Directly addressing this and "shaking it up" will ignite the transformation in unexpected ways. Failure to do this results in a drift toward the status quo.

4. Evaluation criteria need to be developed and directed toward sustaining the transformation momentum. DBH is exploring the performance partnership with providers, the use of 360 degree feedback methods, an accountability partnership and fidelity measures to ground progress according to the overall espoused values of the transformation project.

Practicalities

1. Having developed a vision for their transformed program and subsequently receiving support for that concept by DBH, the agency must complete several practical steps in support of start-up:

   - Facilities – create a plan for facility renovation to be in line with the mission of the new program;
   - Job Descriptions – create new or modify current job descriptions so that functions and knowledge/skills/attitudes fit the new program direction;
   - Certified Peer Specialists – As a key element to the transformation, CPS job descriptions must be completed and approved by DBH. Plans for recruitment and hiring of CPSs must also be part of the implementation plan.
   - Training – Preparing staff through the presentation of new concepts and practices must be a part of the baseline work at the outset of the start-up. Assessment of training needs should be completed 3 months prior to start-up and every three months thereafter to align practice with concept as staff strengths and challenges are discovered within the new practice environment.
   - Create a concrete strategy for the preparation of people in recovery for the transformation.
   - Identify start-up challenges that may be associated with housing, criminal justice, employment resources, co-occurring, etc.
   - Kick-start family inclusion by identifying an easy plug-in of family members into the project.
   - Plan a careful transition of staff from the current program to the new. Meetings, training, individual attention needs to occur to prepare staff for change. Staff will have individual reactions to the shift that must be taken into consideration. Involve all staff with some aspect of the project.
   - Focus on the psychiatric rehabilitation regulations as guidance.
   - Create an initial documentation strategy that is informed by regulation and sound recovery practices.
   - Review current policies for their relationship to the new program. Identify policies and procedures that may become barriers to the transformation. Create new and/or modified policies/procedures as needed.
   - Determine both internal and external data and reporting needs and make preparations and adjustments to current system and procedures. Bring efficiencies to the collection of encounter data.
   - Determine how quality improvement efforts typically completed internally, will be impacted during the first 12 months of start-up. Adjustments to typical QI efforts that recognize the significant shifts occurring in the program may be necessary.
   - Create a marketing strategy for program startup.

- Concretize CPS funding and rollout.
- As stated above, examine the daily schedule of the partial for areas of transformation needed to bring it into alignment with the new program.
- Create initial community partnership plan. Who to partner with, why, anticipated gains, how, product, maintenance of relationship (how?)
- Determine how mobile (community) components will be assimilated in the near term. Recognize that many participants have been isolated, and create methods for initializing community exposure.
- Given the new diversity of staff (coaches, therapists, CPSs, medical, managers, etc.) create a method for both tracking your internal transformation and creating meetings to work out new roles.

- Fiscal
  a) Determine when draw down will begin. Are reinvestment dollars involved? How long? What strategy will be used to take advantage of this opportunity?
  b) Recast operational budget with modifications aligned with new program needs.
  c) Include budgetary items that create bold initiatives in support of the transformation: e.g. consumer-run business, training, support for educational/employment initiatives, transportation, etc.

Unanticipated Gains and Consequences

1. Efforts to support peer culture and peer leadership prior to any formal start-up, have proven helpful to the program's initial efforts.

2. Peers have discovered aspects of one another's lives that have remained hidden within the confines of the partial program. This has ignited and deepened peer relationships which in turn has spirited the initial start-up.

3. The Change Management Teams (CMTs) found that they had to manage the different pace of change that often exists among staff and participants.

4. CPS job descriptions have provided a framework for practice. Relationships among all staff are allowing for greater creativity in assimilating all roles and talents in service to recovering people.

RECOVERY FOCUSED TRAININGS
(APPENDIX IV)

1. **Story-Telling Training:** Recognizing that the stories of people in recovery are a critical tool in moving the transformation forward, DBH/MRS has been offering monthly storytelling training for people in recovery. As a result of this effort, a number of people have gained additional comfort and confidence in sharing their stories with diverse groups. These participants are now sharing their story at the Recovery Foundations trainings and at other venues throughout the system. This training has provided an entry point to other opportunities for participants; several who have participated in the training have consequently been presented with employment opportunities. This powerful initiative has also resulted in requests from providers who want to have storytelling sessions within their organizations.

   For additional information please contact: Ervia Guitterez at 215-685-4866 or email: ervia.guitterez@phila.gov

2. **Family Member Storytelling Training:** This is a wellness and recovery oriented training which recognizes that the stories of Family members are a critical tool in moving Systems Transformation forward. Therefore, the Department of Behavioral Health/Mental Retardation Services, in conjunction with the Philadelphia Compact, is sponsoring free trainings especially for family members of children and/or adults who have received mental health (MH) and/or substance abuse (D&A) services in the city of Philadelphia.

   For additional information please contact: Jazmin Banks at 215-685-4989
   e-mail: Jazmin.Banks@phila.gov

3. **Creating a Culture of Storytelling:**
   Part One: Creating a culture of storytelling for providers: A didactic and experiential workshop that takes providers and people in recovery interested in instituting storytelling circles in their settings through the storytelling workshop

   Prerequisites: none
   Length: 3 hours
   Maximum participants: 20

   Part Two: Presents guidelines, ideas and options for initiating storytelling circles in their settings.
   Prerequisites: Part one for providers or the basic storytelling workshop for people in recovery
   Length: 3 hours
   Maximum participants: 20
   For additional information please contact: Ellen Faynberg at 215-685-5463 or e-mail at: Ellen.Faynberg@phila.gov

4. **Recovery Foundations Training:** This is a training for all of the DBHMRS stakeholders including providers, people in recovery, family, advocates and DBH/MRS staff. The purpose of this training is to provide a theoretical foundation of Recovery Principles as well as give people specific tools for increasing the Recovery orientation in their daily activities.

   For additional information please contact: Shemiah Cooper at 215-685-5504 or e-mail: shemiah.cooper@phila.gov

5. **Recovery Foundations Training-"Train the Trainers":** The first cohort of eleven trainers completed the Recovery Foundations Training "Train the Trainers" workshops. The new trainers are currently providing Recovery Foundations Training at the Behavioral Health Training and Education Network (BHTEN), Mental Health Association (MHA) and Northwestern Human Services (NHS). The RFT "Train the Trainers" initiative has accomplished much more than increasing the frequency of the Recovery Foundations Training. The trainers have developed into a cohesive learning community. They have provided Recommendations for a wide spectrum of Recovery Transformation activities at their agency and within the system as a whole. Numerous stories of Recovery Transformation have emerged in connection with this training. For example, the RFT is now a required training both at MHA and NHS. NHS is building a local speakers bureau which will provide People in Recovery receiving services at NHS an opportunity to participate in an array of events and be paid for their participation. MHA is working on obtaining college credits for participants of the Recovery Foundations Training at their site.

   For additional information please contact: Shemiah Cooper at 215-685-5504 or e-mail: shemiah.cooper@phila.gov,

6. **Person-First: Honoring Diversity and Ending Disparities Training:** Completion of the 2-day Recovery Foundations Training is a pre-requisite for participation in this advanced Recovery Training. The Recovery Foundations Training provides an overview of recovery principles. As we move forward with the transformation process, stakeholders from all parts of the system are increasingly requesting additional training on implementing recovery oriented practices. As part of the Advanced Recovery Training series, this Person-First training will assist all of us in translating recovery principles into everyday practices. As with all our system transformation trainings, we hope to have a diverse group of stakeholders participate to ensure the riches and most effective learning experience possible. Person-First, a key element of recovery/resiliency-oriented services, means that a person's race, ethnicity, language capability, religion, spirituality, gender, gender identity, sexual orientation, social role, age, physical ability, cognitive ability, and/or economic status is acknowledged and incorporated in the delivery of services. The knowledge of these important aspects of people's lives and the communities in which they live should be

integrated and transformed into clinical standards, skills, service approaches, techniques and marketing programs that match Philadelphia's communities and the people living in them. A Person-First approach increases the quality and appropriateness of health care and health outcomes and means that all people are entitled to recovery/resiliency-supporting services that are relevant to them. This training will examine some of the key concepts of Person-First and how to ensure that services being provided in the City of Philadelphia are attentive to them.

For additional information please contact: Omi Sade Ali at 215.599.6350 x136 e-mail: oali@pmhcc.org

7. Person – Directed Planning in Recovery – Oriented Systems of Care Training: Completion of the 2-day Recovery Foundations Training is a pre-requisite for participation in the advanced Recovery Training. The Recovery Foundations training provides an overview of recovery principles. As part of the Advanced Recovery Training series, this Person-Directed planning in Recovery Training provides participants with a concrete set of tools for conducting culturally competent and holistic assessments, it provides participants with increased knowledge and skills for collaboratively developing recovery plans and these tools can be utilized and adapted to suit a variety of contexts.

   For additional information please contact: Shemiah Cooper at 215-685-5504 or email: shemiah.cooper@phila.gov.

8. **WRAP Training:** Wellness Recovery Action Plan (WRAP) training is an integral part of the DBHMRS Recovery-oriented system transformation, and it is one of the cornerstones of the Day Program Transformation. WRAP reflects and promotes Peer Culture/Peer Leadership, a DBH/MRS Recovery Transformation priority area, in that it was developed *by* people in recovery *for* people in recovery and everyone else to reduce distressing feelings and behaviors through a structured system of planned actions. This includes plans of how the person in recovery wants others to respond when symptoms have made it impossible for the individual to make decisions, and keep themselves and others safe. Ultimately, this structured self-management system promotes wellness, increases personal empowerment, improves quality of life, and assists people in achieving their dreams.

   For additional information please contact: Lisa Autry at 215-685-5471 or email: Lisa.Autry@phila.gov

9. **Group Facilitation Skills Training:** This training evolved directly from requests by people in recovery who were interested in starting self help groups in their area. This training provides group facilitation skills, information about the "nuts and bolts" of starting self-help groups, explores group dynamics, and provides connections to existing self help groups. This training is also designed to inform the system about the benefits of self-help groups and provides self-help group

facilitators an opportunity to develop a natural learning and support community with each other.

For additional information please contact: **Seble Menkir at 215-685-5498 or E-Mail: Seble.Menkir@phila.gov**

10. **Certified Peer Specialist Initiative:** Philadelphia has made a commitment to train and hire 100 certified peer specialists (CPS). To date 57 people have been certified as peer specialists and of those over half are employed. The next training application period will be in early 2008.

    For additional information please contact: Michelle M. Davis at 215-685-5464 or E-Mail: Michelle.M.Davis@phila.gov

11. **Taking Recovery to the Streets: Program to Educate Peers About Recovery:** In support of the day system transformation, DBH/MRS is offering training for people in recovery by people in recovery from mental health and addiction issues. The training is designed to introduce and expand the concept of recovery in an exciting format designed to help people in recovery empower themselves. Participants will discuss their definitions of recovery, explore wellness tools they can use and evaluate their resources.

    To schedule your training please contact: Wendy Williams-Blackson at 215-685-5468 or E-Mail: Wendy.Williams-Blackson@phila.gov

12. **Drexel Introduction to Psychiatric Rehabilitation Training:** This training introduces the concepts and practice of psych rehab. Dates for the training will be announced as soon as they are available from Drexel.

    For additional information please contact: Wendy Williams-Blackson at 215-685-5468 or E-Mail: Wendy.Williams-Blackson@phila.gov

13. ***Consumer Training Program "Train the Trainer":*** *Wilma Townsend, nationally recognized recovery consultant, trained a cadre of people in recovery who are currently training their peers on developing their personalized recovery management plans.*

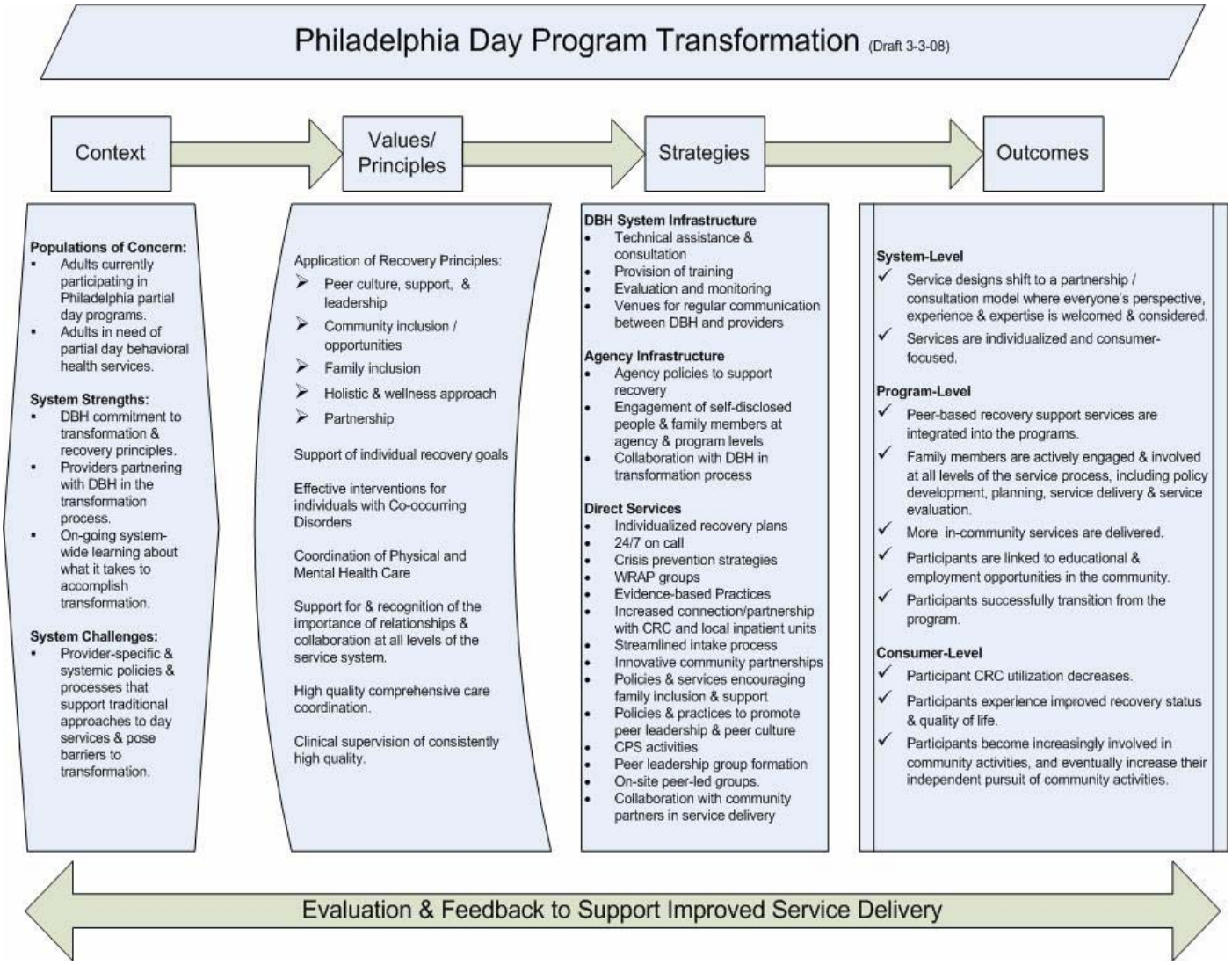
For additional information please contact: **Alysa Swede at 215-599-2150 x3216 or E-Mail: ASwede@pmhcc.org**

14. **Day Transformation Core Trainings on various topics:** A series is currently being developed for 2008. Information will be distributed to all agencies providing day services.

    For additional information please contact: Wendy Williams-Blackson at 215-685-5468 or E-Mail: Wendy.Williams-Blackson@phila.gov

THE PHILADELPHIA DAY TRANSFORMATION LOGIC MODEL

(APPENDIX V)



DEPARTMENT OF BEHAVIORAL HEALTH AND MENTAL RETARDATION SERVICES

CERTIFIED PEER SPECIALIST JOB DESCRIPTION TEMPLATE: COMMUNITY INTEGRATION SPECIALIST

(APPENDIX VI)

The functions indicated below are to be performed by Certified Peer Specialists/Community Integration Specialists (CIS) and will be eligible for reimbursement by the Department of Behavioral Health (DBH). Depending upon the type of program employing CISs, some of these functions may not be relevant and may be excluded. No additional functions, however, may be added to the job description unless they are specifically requested and approved by DBH.

The ability to share personal recovery experiences and to develop authentic peer-to-peer relationships is essential to effective CIS performance. Consequently, CISs must hold the following beliefs and demonstrate the following qualities:

- A personal belief in recovery
- A genuine hope and optimism that their peers will succeed
- A sincere interest in the welfare of their peers, including the ability to see each person as a unique individual
- A willingness to share their own recovery experience
- An ability to flexibly engage people based on their level of receptivity and individual needs, acknowledging that even the same person may need different types of peer-based services at different points in their recovery process.

Duties and Functions:

1. Recovery Education

    a. Recovery education should span every phase of the recovery journey from pre-recovery engagement, recovery initiation, recovery stabilization, and sustained recovery maintenance.

    b. Provide vision driven hope and encouragement regarding opportunities for varying levels of involvement in community based activities (e.g., work, school, relationships, physical activity, self-directed hobbies, etc.).

    c. Provide a model for both people in recovery and staff by demonstrating that recovery is possible.

d. Educate professional staff about the recovery process, the damaging role that stigma can play in undermining recovery.

2. Assist Peers to Assess Unique Strengths and Abilities

a. Identify Recovering Persons' abilities, strengths and assets (both internal and external) and assist them to recognize these strengths and use them to achieve their goals.

3. Community Integration and Recovery Goal Development and Planning

a. Assist recovering persons to identify their personal interests and goals in relationship to recovery and to "getting the life they want" in the community.

b. Connect recovering persons to WRAP groups to develop their own plans for advancing their recovery.

c. Assertively support connections to community based, mutual self-help groups.

4. Promote Self-Advocacy

a. Assist recovering persons to have their voices fully heard and their needs, goals and objectives established as the focal point of rehabilitation and clinical services.

b. Support recovering persons to identify their area of need for professional supports and services, and then communicate those needs to provider staff.

5. Assertive Linkage to Professional Assessment/Treatment Services

a. Link individuals to appropriate professional resources when needed.

6. Identify Community Resources

a. Identify community resources (communities of recovery, educational, vocational, social, cultural, spiritual resources, etc) that support the recovering person's goals and interests. This will involve a collaborative effort including the recovering person, as well as agency staff and other relevant stakeholders.

b. Identify barriers (internal and external) to full participation in community resources and developing strategies, with other stakeholders, to overcome those barriers.

7. Community Liaison

   a. Develop relationships with community groups/agencies in partnership with others in the agency.

8. Connect Persons to Community Resources

   a. Discuss with recovering persons possible matches and opportunities between their interests and community resources.

   b. Link recovering persons to self help and mutual support groups that exist in the community

   c. Visit community resources with recovering persons to assist them in becoming familiar with potential opportunities.

   d. Teach recovering persons, in real world settings, the skills they need to successfully utilize community resources.

   e. Coach recovering people in the independent use of community supports.

9. Recovery Planning

   a. Facilitate (via personal coaching and WRAP groups) the transition from a professionally directed service plan to a self-directed Recovery Plan. The goal should be to transition from professionally assisted recovery initiation to personally directed, community supported recovery maintenance.

10. Long-term Engagement, Support, and Encouragement

    a. Maintain contact by phone and/or e-mail with recovering person after they leave the program to insure their on-going success and to provide re-engagement support in partnership with others in the agency if needed.

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
PSYCHIATRIC REHABILITATION MEDICAL NECESSITY
CRITERIA AND STANDARDS

(APPENDIX VII)

See attached PDF file