Action Plan Selection Guide – A Tool for Self-Management Support

The Self-Management Support (SMS) Action Plan Selection Guide was developed to support behavioral health providers in choosing action plans that best meet the needs of their clients and their organization – a key step to effectively delivering SMS. Action planning is particularly useful for clients with mental illness, substance abuse disorders, chronic conditions, and/or co-occurring disorders. This Selection Guide includes key information that providers may consider when selecting action plans for use within their organization.

Action Planning – A Key Component of SMS

SMS is a long-term, continuous process toward recovery involving the systematic provision of educational and supportive interventions by health care providers to improve clients' skills in managing their own health issues.[1] Goal setting through action plans, a key element of SMS, includes working with clients and their natural supports to formulate short-term objectives for their health and develop specific steps for crisis management. Further, action planning has been identified as one of the six skills that promote successful SMS, facilitating the provider-client discussion and creating a reference document for providers, clients, and other members of the clinical care team.[2]

Additional tools, concept guides, and client handouts related to SMS can be found at the following website:

https://www.resourcesforintegratedcare.com/concepts/self-management-support

Action Plan Selection Guide – A Tool for SMS

The SMS Action Plan Selection Guide identifies core features of available action plans that may be useful to providers in selecting the appropriate action plan for their clients. In addition, the Selection Guide includes peer-reviewed evidence about the effectiveness of each action plan listed, as well as a selection of resources to help providers better support the self-management of their clients.

Key Features of Action Plans

Key features, included in the Selection Guide, may help providers select a plan that best fits their clients' needs. The table on Key Features of Action Plans provides the following information for each action plan:

- Client population – action plans' target client population (e.g., patients with serious mental illness)
- Intervention or method of implementation – structure and context for how the action plan is delivered to clients (e.g., individual or group)

[1] Adams K, Corrigan JM, editors. Institute of Medicine. Priority areas for national action: Transforming health care quality. Washington, DC: National Academies Press; 2003.
[2] Lorig, K. R., & Holman, H. R. (2003). Self-Management Education: History, Definition, Outcomes, and Mechanisms. *Annals Of Behavioral Medicine*, 26(1).

- Estimated time per session – estimated amount of time to complete each session or module of the action plan
- Frequency of action plan updates – how often clients are expected to update their action plans
- Approach to goal-setting – steps involved in achieving the clients' goals, which may include the level of client effort, frequency of client engagement, or timing of the goal-setting activity
- Identification of triggers/warning signs – whether the action plan prompts providers and clients to identify potential triggers or warning signs for the client
- Client self-rated scales – whether the action plan uses a client self-rated scale to determine clients' confidence in their ability to meet action plan goals

Evidence of Effectiveness

Peer-reviewed studies demonstrating the effectiveness of each action plan are also included in the Selection Guide. Researchers have evaluated some of the action plans in randomized controlled trials (RCTs) whereas others have not undergone peer-reviewed evaluations. The citation selected for inclusion references the study that presents the strongest evidence for a particular action plan. For action plans that have been rigorously tested and found to be effective, the following aspects of the studies are displayed in the table:

- Study design
- Study population
- Length of study
- Study replication
- Measures and instruments
- Description of findings
- Citation

Key Details for Implementation

Provider organizations may also be interested in the operational details of each plan. The table on Key Details for Implementation provides the following information for each action plan:

- Staff training options
- Licensing and certification requirements
- Cost of training, licensing, and certification
- Available manuals or tools to assess fidelity
- Available technical assistance resources

Resources

Additional information about each listed action plan can be found in the Resources section at the end of the document. Resources include non-peer-reviewed studies that evaluate the action plan, action plan templates and examples, adaptations of the action plan, client testimonies, and other relevant action planning and SMS tools that are available online.[3]

[3] For information on engaging patients in action planning and self-management, see the America Academy of Family Physicians Foundation's Engaging Patients in Collaborative Care Plans guide.

Key Features of Action Plans

Action Plan	Client Population	Method of Implementation and Interdisciplinary Care Team Involvement	Estimated Time per Session	Frequency of Action Plan Updates	Approach to Goal Setting	Identification of Triggers / Warning Signs	Client Self-Rated Scales
Brief Action Planning (BAP), "Taking Care of My Health or Well-Being"	Chronic illnesses	One-on-one, face-to-face patient-provider meetings	3–20 minutes per meeting	Week(s)	Client identifies a specific, actionable goal; client identifies actions to work toward achieving goal; where, how much, how often, and when action will occur; specific start date; and how and when client will check or self-check progress	No identification of barriers and challenges	Confidence scale
CHCF Team Up for Health Action Planning Form	Chronic illnesses	Clinical care team approach	-	1 Week	Client identifies a goal; client chooses one of the following activities to reach goal: "Work on something that's bothering me," "Stay more physically active," "Take my medications," "Improve my food choices," "Reduce my stress," or "Cut down on smoking"; client identifies what, how much, when, how often, where, with whom, start date, and follow-up.	Plan includes an 8-week calendar; clients draw an "O" for each day the action plan was set. If the goal for that day was reached, they check off the circle; helps clients to identify challenges in the plan, which they explain below the calendar	Confidence scale
Harlem Family Action Plan for Better Health	HIV/AIDS	Clinical team approach (nurse, provider, case manager, and patient)	-	1 Month	Client identifies a specific, actionable goal. Plan suggests adherence to medication, increasing exercise, reducing stress, follow-up with a medical appointment, attending a support group and substance use reduction or cessation. Client describes action: How, where, what, when, how often	Client identifies barriers and plans to overcome barriers	Importance scale; Confidence scale
Health and Recovery Peer (HARP) Program	SMI (Serious Mental Illness); comorbid conditions	(Adapted from Stanford Chronic Disease Self-Management Program CDSMP) 6-week community-based group workshop; 2 non-health professional facilitators with chronic diseases;	90 minutes per workshop session	1 Week	Client identifies a specific, actionable goal; client identifies a specific action to work toward achieving goal; how much, how often, and when action will occur; plans should focus on the mind-body connection; strength-based approach to goal setting	Modified from CDSMP – diet and exercise portion of plan provides strategies for overcoming lack of access to healthy foods and ways to exercise safely	Confidence scale

Action Plan	Client Population	Method of Implementation and Interdisciplinary Care Team Involvement	Estimated Time per Session	Frequency of Action Plan Updates	Approach to Goal Setting	Identification of Triggers / Warning Signs	Client Self-Rated Scales
		participants are paired with a partner from the group					
Illness Management and Recovery Program	SMI, substance use	Individual or group format; 45- minute to hour-long meetings at least once a week for 4 weeks; led by a facilitator and IMR leader	45 minutes – 1 hour per meeting	Week(s)	Client identifies specific and simple goals; client identifies possible actions to carry out the goal and chooses the best option; identifies who will help the client achieve the goal, when actions occur, and other resources; follow-up date set; strength-based approach to goal setting	Client identifies potential problems and possible solutions to overcome problems	No self-rated scales identified
Individual Recovery Plan (Council of Southeast Pennsylvania, Inc.[4])	Substance use disorders; co-occurring disorders	One-on-one, face-to-face with a Certified Recovery Specialist (CRS is a trained supervised provider of recovery support services with lived experience of recovery from SUD/COD)	60-90 minutes for initial session; subsequent meetings based on participant's needs and progress	Every 90 days at minimum; plan is reviewed/updated approx. each week, depending on client needs	Prior to goal setting, the client and CRS complete a strengths-based assessment, then set a specific, measurable, action-oriented, realistic and time-framed goal in one or more life domains (e.g. abstinence from substances, psychological health, social support); goal constructed with objectives or action plan steps outlining the client's role and the role of the CRS; where, when, frequency and duration of actions; and target date for completion of steps	While not included in the plan, clients work with CRS to identify potential barriers and challenges to meeting their goals in addition to strengths/assets	Satisfaction rating
Institute for Healthcare Improvement Action Plan, "Partnering in Self-Management Support: A Toolkit for Clinicians"	Chronic illnesses	Clinical team approach (nurse or medical assistant, provider, nutritionist, PT, OT, clerical staff, and patient)	No time specified, planned care visit workflow available online – login required	1 Week	Client identifies a specific, actionable goal; client identifies a specific action to work toward achieving goal; where, how, what frequency, and when action will occur	Client identifies barriers and plans to overcome barriers	Conviction scale; Confidence scale
MaineHealth Self-Care Plan	Chronic illnesses	One-on-one, face-to-face patient-provider meetings	-	1 Week	Client identifies one goal to accomplish; client identifies one action to achieve goal; How much, how often, and when action will occur; identification of friends and family to help client meet goal	No identification of barriers and challenges	Confidence scale

[4] This action plan is not accessible online. Please contact The Council of Southeast Pennsylvania, Inc. for more information: 1-215-345-6655.

Action Plan	Client Population	Method of Implementation and Interdisciplinary Care Team Involvement	Estimated Time per Session	Frequency of Action Plan Updates	Approach to Goal Setting	Identification of Triggers / Warning Signs	Client Self-Rated Scales
New York State Wellness Self-Management + (WSM +)	SMI, substance use, lifestyle challenges	Weekly group meetings for approximately one year; 8-12 participants per group; staff with various credentials and peer specialists may facilitate the program	45-60 minutes per session	Approx. 1 Week	Client identifies goals that correspond to each weekly lesson; client identifies possible actions to carry out the goal and chooses the best option; when actions occur, and other resources; strength-based approach to goal setting	Client identifies barriers to achieving goals and creates a plan to learn more about those barriers; client identifies natural social supports	No self-rated scales identified
Penn Foundation Integrated Wellness Recovery Plan, (see Appendix B)	SMI, substance use, intellectual disabilities, physical health issues, lifestyle challenges	Clinical team approach (RN Navigator, Recovery Coach, BH Navigator, Outpatient Therapist, Peer Support Specialist, patient)	-	90 Days	Client identifies 3 long-term goals and 3 short-term change goals; client identifies target dates for goals, cues that the goal is achieved, supports, and outcomes; Includes planning for communication with psychiatrist and PCP; strength-based approach to goal setting	Client identifies 3 areas that he or she would like to work on; Provider team notes Behavioral Health Diagnoses, Personality/MR Diagnosis, Physical Health Diagnoses, and other Stressors	No self-rated scales identified
Stanford Chronic Disease Self-Management Program (CDSMP) Action Plan	Chronic illnesses	6-week community-based group workshop; 2 non-health professional facilitators with chronic diseases	90 minutes per workshop session	1 Week	Client identifies a specific, actionable goal; client identifies a specific action to work toward achieving goal; how much, how often, and when action will occur; strength-based approach to goal setting	No identification of barriers and challenges	Confidence scale
Wellness Recovery Action Plan	Mental illnesses; lifestyle challenges; chronic illnesses	Group class; 8 weekly 2-hour sessions; 2 peer co-facilitators; class sizes range from 8 to 12 participants	2–2.5 hours per weekly session	One-time development of plan; daily review of developed plan	Client describes him or herself when he or she is feeling well and identifies Wellness Tools that are necessary to maintain wellness on a daily basis; Client utilizes identified Wellness Tools to develop action plans to respond to early warning signs of being unwell and more advanced warning signs of being unwell; client develops a Crisis Plan to let others know they must take responsibility for the client's care; Client develops a Post Crisis Plan to recover from a crisis; strength-based approach to goal setting	Identification of triggers that may cause client to feel unwell; identification of warning signs that the client is feeling unwell	No self-rated scales identified

Action Plan	Client Population	Method of Implementation and Interdisciplinary Care Team Involvement	Estimated Time per Session	Frequency of Action Plan Updates	Approach to Goal Setting	Identification of Triggers / Warning Signs	Client Self-Rated Scales
Whole Health Action Management (WHAM) Plan	Mental illnesses; substance use disorders	8-week peer support group with group sessions and individual meetings	60-90 minutes per group session; 15-30 minutes per individual meeting	1 Week	Client identifies a goal that is new and whole-health oriented; client identifies a specific action to work toward achieving goal; how much, how often, and when action will occur; strength-based approach to goal setting	No identification of barriers and challenges	Confidence scale

Evidence of Effectiveness

Action Plan	Study Design	Study Population	Length of Study	Was the study replicated?	Measures & Instruments	Description of findings	Selected Citation
Brief Action Planning (BAP)	One-arm, pre-/post-/post-test	13 peers with spinal cord injury	Outcomes assessed after half-day workshop and at 1 month follow-up	No	Note: Client outcomes not measured BAP and motivational interviewing spirit competence; training satisfaction; motivations to use BAP Based on measures of the theory of planned behavior constructs	Participants in the BAP workshop showed significant increases in BAP and motivational interviewing competence. All means of training satisfaction fell above the scale midpoint. Additionally, participants' perceived behavioral control to use BAP increased after the workshop, but was not maintained at 1 month follow-up.	Gainforth, H. L., Latimer-Cheung, A. E., Davis, C., Casemore, S., & Martin Ginis, K. A. (2014). Testing the feasibility of training peers with a spinal cord injury to learn and implement brief action planning to promote physical activity to people with spinal cord injury. The Journal Of Spinal Cord Medicine.
CHCF Team Up for Health Action Planning Form	*Note: This action plan has not been formally evaluated in a peer-reviewed study.*						
Harlem Family Action Plan for Better Health	*Note: This action plan has not been formally evaluated in a peer-reviewed study.*						
Health and Recovery Peer (HARP) Program	Randomized Controlled Trial	80 adults 18 and older with SMI with one or more chronic medical illness	Outcomes assessed at 6 month follow-up	No	Patient activation, disease self-management, HRQOL, social vulnerability, medical vulnerability 13-item Patient Activation Measure (PAM), Behavioral Risk Factor Surveillance System, SF-36	After 6-month follow-up, adults that participated in the HARP program, compared with those in usual care, saw a significantly greater improvement in patient activation. Additionally, HARP participants showed greater improvement in rates of having one or more primary care encounters. For those who participated in HARP, there were significant improvements across measures for those among "medically and socially disadvantaged groups."	Druss, B. G., Zhao, L., von Esenwein, S. A., Bona, J. R., Fricks, L., Jenkins-Tucker, S., & ... Lorig, K. (2010). The Health and Recovery Peer (HARP) Program: A peer-led intervention to improve medical self-management for persons with serious mental illness. Schizophrenia Research, 118264-270. doi:10.1016/j.schres.2010.01.026

Action Plan	Study Design	Study Population	Length of Study	Was the study replicated?	Measures & Instruments	Description of findings	Selected Citation
Illness Management and Recovery Program	Randomized Controlled Trial	210 people with SMI receiving treatment at rehabilitation centers in Israel	Outcomes assessed at 8-month completion of IMR program	Yes	Personal goals, knowledge of mental illness, involvement with significant others, functioning, symptoms, stress, coping, relapse prevention, hospitalization, medication, and substance use Coping Efficacy Scale, Multidimensional Scale of Perceived Social Support, Illness Management and Recovery Fidelity Scale	Participants that completed the IMR program, compared with those receiving usual care, showed significantly improved knowledge of illness and identification and attainment of personal goals. Additionally, clinicians of clients participating in IMR indicated significant improvement in overall illness management and recovery outcome. There were no differences between the IMR and control groups with regard to coping efficacy.	Hasson-Ohayon I., Roe D., Kravetz S. A randomized controlled trial of the effectiveness of the illness management and recovery program. Psychiatr Serv 2007;58:1461-1466.
Individual Recovery Plan (Council of Southeast Pennsylvania, Inc.)	*Note: This action plan has not been formally evaluated in a peer-reviewed study.*						
Institute for Healthcare Improvement Action Plan	*Note: This action plan has not been formally evaluated in a peer-reviewed study.*						
MaineHealth Self-Care Plan	*Note: This action plan has not been formally evaluated in a peer-reviewed study.*						
New York State Wellness Self-Management + (WSM +)	One-arm, pre-/post-/post-test	409 WSM participants in 212 WSM groups	Data collected over 2-year period	No	Key performance indicators including attendance, discontinuation and reasons why, client self-assessment of progress, group leader ratings of participant involvement, goal progress; fidelity ROPES fidelity checklist	Participants and WSM group leaders indicated that participants showed significant progress in achieving goals over the course of the program; majority of participating agencies continued to provide WSM at 10-month follow-up	Salerno, A., Margolies, P., Cleek, A., Pollock, M., Gopalan, G., & Jackson, C. (2011). Wellness Self-Management: An Adaptation of the Illness Management and Recovery Practice in New York State. Psychiatr Serv., 62(5): 456-458. doi: 10.1176/appi.ps.62.5.456

Action Plan	Study Design	Study Population	Length of Study	Was the study replicated?	Measures & Instruments	Description of findings	Selected Citation
Penn Foundation Integrated Wellness Recovery Plan	*Note: This action plan has not been formally evaluated in a peer-reviewed study.*						
Stanford Chronic Disease Self-Management Program (CDSMP) Action Plan	Randomized Controlled Trial	952 patients 40 or older with a confirmed diagnosis of heart disease, lung disease, stroke, or arthritis	Outcomes assessed at 6 month follow-up	Yes (see HARP Program)	Health behaviors, health status, health service utilization Modified scales from the National Health Interview Survey, the Health Assessment Questionnaire (HAQ), and the Medical Outcomes Study (MOS)	Those who participated in the CDSMP intervention showed significant improvement in health behavior and health status variables in comparison with the control group receiving usual care. The treatment group also had fewer hospitalizations and spent, on average, fewer nights in the hospital. There were no significant differences demonstrated for pain and physical discomfort, shortness of breath, psychological well-being, or visits to physicians between the two groups.	Lorig, K. R., Sobel, D. S., Stewart, A. L., Brown, W., Bandura, A., Ritter, P., & Holman, H. R. (1999). Evidence Suggesting That a Chronic Disease Self-Management Program Can Improve Health Status While Reducing Hospitalization: A Randomized Trial. Medical Care, (1). 5.
Wellness Recovery Action Plan	Randomized Controlled Trial	519 adults with SMIs receiving publicly funded outpatient psychiatric services	Outcomes assessed after 8-week intervention and at 6-month follow-up	Yes	Reduction of psychiatric symptom severity, severity of illness, number of symptoms endorsed in a pathological direction, improvement in hopefulness and quality of life Brief Symptom Inventory (BSI), Global Severity Index, BSI Positive Symptom Total, Hope Scale (HS), World Health Organization Quality of Life Brief instrument (WHOQOL-BREF)	Compared to the control group, participants in the WRAP program showed greater reduction over time in Brief Symptom Inventory Global Symptom Severity and Positive Symptom Total, greater improvement over time in hopefulness, and enhanced improvement over time in quality of life immediately post-intervention and at 6-month follow-up.	Cook, J. A., Copeland, M. E., Jonikas, J. A., Hamilton, M. M., Razzano, L. A., Grey, D. D., et al. (2012). Results of a randomized controlled trial of mental illness self-management using Wellness Recovery Action Planning. Schizophrenia Bulletin, 38(4), 881-891. PMID: 2402724
Whole Health Action Management (WHAM) Plan	*Note: This action plan has not been formally evaluated in a peer-reviewed study.*						

Key Details for Implementation

Action Plan	Staff Training Options	Licensing and Certification	Cost (Training, Licensing, and Certification)	Available Manual or Tool to Assess Fidelity?	Technical Assistance Resources Available?
Brief Action Planning (BAP)	Online or face-to-face training in BAP, practice, and a final exam with standardized patients for Certification in BAP; 2.5-day train the trainer workshop for BAP Trainer Certification	Certification in BAP; BAP Trainer certification	Information available upon request (contact BAP)	Yes (available through training)	info@cetrecmi.ca 1-788-220-2217
CHCF Team Up for Health Action Planning Form	None	None	Free	No	No
Harlem Family Action Plan for Better Health	None	None	Free	No	No
Health and Recovery Peer (HARP) Program	None	None	Free	No	No
Illness Management and Recovery Program	Home study; training manuals available online	None	Free	Yes	No
Individual Recovery Plan (Council of Southeast Pennsylvania, Inc.)	Certified Recovery Specialist (CRS) training (training on recovery planning process); orientation/on-the-job training	None (at the Council, CRSs credentialed through Pennsylvania Certification Board)	Free	No	The Council of Southeast Pennsylvania, Inc. 1-215-345-6655 *technical assistance and consultation fees apply
Institute for Healthcare Improvement Action Plan	Manual for clinicians available online	None	Free	No	No
MaineHealth Self-Care Plan	None	None	Free	No	No

Action Plan	Staff Training Options	Licensing and Certification	Cost (Training, Licensing, and Certification)	Available Manual or Tool to Assess Fidelity?	Technical Assistance Resources Available?
New York State Wellness Self-Management + (WSM +)	Online trainings; self-study	None	Free	Yes	No
Penn Foundation Integrated Wellness Recovery Plan	None	None	Free	No	No
Stanford Chronic Disease Self-Management Program (CDSMP) Action Plan	On-site 4.5-day training for at least two staff members or lay person with chronic disease (required); Master "Away Training" program; online cross-training supplemental program	Single-program license or multiple-program license; expires 3 years after issue	$500-1,500 per organization (Single-program license); $16,000 per organization (Master "Away Training" program) $1700 per health professional (on-site training); $1000 per lay person with chronic disease (on-site training)	Yes	Self-management@stanford.edu 650-723-7935 For licensing issues: Self-manage-licensing@stanford.edu For training issues: Self-manage-training@stanford.edu
Whole Health Action Management (WHAM) Plan	2-day in-person training	WHAM facilitator certification	Information available upon request (contact WHAM)	No	For training requests: dawnt@thenationalcouncil.org
Wellness Recovery Action Plan	3-part seminar including an introduction to mental health recovery and WRAP, a WRAP facilitation certificate course, and an option Advanced Level WRAP Facilitator Training certificate course (required)	WRAP Facilitator Training certification (required) WRAP Center of Excellence certification (optional)	$1,300 per person (WRAP facilitation certificate course) Approx. $3,000-5,000 per organization (Center of Excellence certification application); $250-1,000 per organization (Center of Excellence certification annual fees)	Yes	Copeland Center TA Website 802-254-5335

Resources

Brief Action Planning (BAP)

Available at: http://www.centrecmi.ca/wp-content/uploads/2013/08/BAP_Goal_Setting_Worksheet_2015-03-16-copy-2.pdf

- BAP is a self-management support technique that is structured around core questions and topics providers can discuss with patients. The **Brief Action Planning Guide** is available for download online along with a **Flow Chart** to help facilitate patient-provider conversations.
- More detailed information is offered about BAP on the **Centre for Collaboration Motivation & Innovation website**.
- **Brief Action Planning to Facilitate Behavior Change and Support Patient Self-Management**, is an article published in the Journal of Clinical Outcomes Management that describes Brief Action Planning (BAP) and provides a review of the evidence that supports the program.
- The **BAP Videos website** features video demonstrations of BAP in various settings.

CHCF Team Up for Health Action Planning Form

Available at: http://www.chcf.org/projects/2011/team-up-for-health

- Six health care delivery systems were selected to participate in the California HealthCare Foundation's 2009 Team Up for Health Initiative, which sought to improve SMS through engaging experts and providing training and technical assistance.

- A 2011 external evaluation, **Evaluation of the California HealthCare Foundation's Team Up for Health Initiative**, found that the grantees that participated in the initiative reported positive changes for the majority of patient experience and self-care behavior measures, patient clinical processes and outcomes measures, and provider satisfaction with SMS measures.

Harlem Family Action Plan for Better Health

Available at: http://cdn.hivguidelines.org/wp-content/uploads/Harlem-My-Action-Plan-for-Better-Health.pdf

- A description of Harlem Hospital's action planning tool and its pilot test is available in a **National Quality Center PowerPoint**, accessible online.

Health and Recovery Peer (HARP) Program

- The HARP Program was developed and pilot-tested, with 6-month follow-up results showing clinically and statistically significant improved measures of patient activation,

significant improvement in primary care follow-up, and increased time per week spent exercising. The **full study** is available on PubMed.

Illness Management and Recovery (IMR) Program

Available at: https://store.samhsa.gov/shin/content/SMA09-4463/PractitionerGuidesandHandouts.pdf

- This SAMHSA program increases a consumer's ability to problem solve, manage illness, and pursue personal recovery goals. Materials are available through **SAMHSA's publications page** and include Practitioner Guides and Handouts.
- **The Evidence**, one component of the complete IMR toolkit, reviews research articles that demonstrate the evidence of effectiveness of the IMR Program, as well as potential program challenges and ways to tackle them.

Individual Recovery Plan (Council of Southeast Pennsylvania, Inc.)

For more information about the Individual Recovery Plan, please contact Stacey Conway at The Council of Southeast Pennsylvania, Inc. (215-345-6644 ext. 3107; sconway@councilsepa.org)

- The Council of Southeast Pennsylvania conducted an internal program evaluation of the Council's Peer-Based Recovery Support Services. The study population included 225 adults with self-identified substance use or co-occurring disorders completing an initial Individual Recovery Plan and receiving peer-based recovery support services. The evaluation found increases in average scores from baseline to the most recent scores in all ten life domains of the Assessment of Recovery Capital instrument (Groshkova, Best, and White, 2012) and all four domains of the World Health Organization's Quality of Life Short Form. Additionally, there were increases in average scores in overall perception of quality of life and overall perception of quality of health.

Institute for Healthcare Improvement Partnering in Self-Management Support Action Plan

Available at: http://www.ihi.org/resources/Pages/Tools/SelfManagementToolkitforClinicians.aspx

- A profile of the IHI Partnering in Self-Management Support toolkit for clinicians is available in **AHRQ's Self-Management Support Resource Library**. The profile summarizes the tool and provides instructions for how to access the tool.

MaineHealth Self-Care Plan

Available at:

http://media.mycme.com/documents/13/mdd-self-care_action_plan_3074.pdf

- The report, **Helping Patients Help Themselves: How to Implement Self-Management Support**, provides a description of MaineHealth's primary care behavioral health program.

New York State Wellness Self-Management (WSM) and Wellness Self-Management + (WSM+)

Available at:
http://practiceinnovations.org/CPIInitiatives/WellnessSelfManagement(WSM)/WellnessSelfManagement(WSM)Plus/tabid/184/Default.aspx

- The New York State WSM+ is an adaptation of the Illness Management and Recovery (IMR) model. WSM+ differs from IMR in that it expands the IMR curriculum to include physical health concerns, action planning takes place during the lesson rather than at home, it is group-facilitated, practitioner core competencies are embedded into the workbook, and the workbook is bound with structured lessons. WSM+ also addresses substance use in addition to SMI.
- More information about WSM + can be found at the **New York State Office of Alcoholism and Substance Abuse Services website**.
- The **WSM Library**, hosted on the Center for Practice Innovations at Columbia Psychiatry website, houses downloadable WSM documents include brochures and tip sheets as well as promotional videos.

Penn Foundation Integrated Wellness Recovery Plan

Available at:
https://www.resourcesforintegratedcare.com/sites/default/files/Approaches%20to%20Supporting%20Self-management%20for%20Individuals%20with%20SMI.pdf (Appendix B)

- The Integrated Wellness Plan developed by the Penn Foundation, a specialty behavioral health provider agency in Montgomery County, PA, can be used by navigators or other clinicians to develop collaborative goals with consumers and provide follow up over time.

Stanford Chronic Disease Self-Management Program (CDSMP)

Available at: http://patienteducation.stanford.edu/programs/cdsmp.html

- The **CDSMP Outcomes Review from CDC and NCOA** summarizes the findings of eight major studies published between 1999 and 2007 that evaluate the outcomes of the CDSMP. Overall, the studies found that the program results in significantly improved patient outcomes and quality of life, while decreasing health care spending.
- The program has been adapted for individuals with **diabetes**, **chronic pain**, **HIV/AIDS**, **arthritis**, and for **cancer survivors**.

Wellness Recovery Action Plan (WRAP)

Available at: http://www.mentalhealthrecovery.com/wrap/

- A number of research studies have been published that assert the effectiveness of the WRAP intervention. Some of the key publications on the subject are listed on the **WRAP Recovery webpage**.

- There is a **WRAP profile** in SAMHSA's National Registry of Evidence-based Programs and Practices.
- The Copeland Center for Wellness and Recovery, an organization that provides WRAP training, consultation, and program activities, features several **videos** on its website that feature interviews with WRAP's author and WRAP facilitators.

Whole Health Action Management (WHAM)

Available at: http://www.integration.samhsa.gov/health-wellness/wham

- WHAM was developed by the SAMHSA-HRSA Center for Integrated Health Solutions. The **Peer Support Training Participant Guide** is available for download online in both English and Spanish.