

Self-Management Support in Behavioral Health

ORGANIZATIONAL ASSESSMENT TOOL

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Introduction

Purpose

This assessment tool is designed to assist behavioral health organizations in delivering self-management support to clients managing serious mental illness and/or substance abuse conditions. These conditions often coincide or are dually diagnosed; an estimated 50 percent of individuals with a serious mental illness also have a substance abuse condition.¹ Supporting clients in managing their health is the responsibility of front-line providers, administrators, and recovery support leaders. This tool allows organizations to assess their capacity for delivering self-management support and also outlines a quality assurance process that facilitates ongoing organizational improvements in self-management support.

Self-Management Support

The Institute of Medicine (IOM) describes self-management as “the tasks that individuals must undertake to live well with one or more chronic conditions.”¹ When individuals gain self-management skills and use these skills over time they gain autonomy over their health and their health care choices, which may lead to longer, healthier lives. Providing self-management support is, therefore, a key activity for health care providers seeking to deliver integrated, high quality health care.²⁻⁵

Self-management has been demonstrated to increase individuals’ satisfaction with health care, reduce the cost of care, and improve health outcomes for persons with a variety of chronic health conditions.⁶⁻¹¹ Self-management is especially applicable to individuals with serious mental illness and to those with substance abuse conditions. Previous studies have demonstrated how self-management programs can improve health outcomes for those with serious mental illness and other comorbid chronic illness.⁶ Persons with serious mental illness or substance abuse conditions can use self-management skills to manage their behavioral and physical conditions, maintain their overall health, and maximize their quality of life.

For persons with serious mental illnesses and/or substance abuse disorders, self-management support is integral to promoting and sustaining recovery. The concept of recovery and peer support has been central to the self-management of addictive disorders. Health

Key Terms

Self-Management Support

Self-management support is “the systematic provision of education and supportive interventions by health care staff to increase clients’ skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support.”^{2,3,4} Self-management support has similarities to interventions used in addiction disorders, such as motivational enhancement therapy.

Recovery

Recovery is the “process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”¹² Recovery represents a broader perspective of health, which considers health to be not only the absence of disease, but optimal quality of life (e.g., housing, relationships, purpose, and community integration) and reaching one’s goals and potential. Self-management support reflects this broad view of health and extends to all aspects of an individual’s life.

Client

Providers may use a variety of terms when referring to individuals receiving health care services including “patient” and “consumer.” For the purposes of this document, these individuals are defined as “clients.”

Natural Supports

Clients may have a variety of individuals that support their recovery including family members, friends, other loved ones, neighbors, and employers. For the purpose of this document, these individuals are referred to as “natural supports.”⁷

- defined as managing one's disease *and* making informed, healthy choices that support physical and emotional wellbeing - is one of four dimensions of recovery, along with home, purpose and community. A guiding principle of these dimensions is that recovery is person-driven with self-determination and self-direction as the foundations for recovery.¹³ Efforts to better support self-management are well aligned with the goals and processes many organizations are pursuing as they adopt the recovery model.

Delivering Self-Management Support in Behavioral Health

For many providers, supporting self-management involves a paradigm shift away from the traditional medical model towards a shared decision-making model for encounters with clients. It means staff and organizations must structure and deliver care in ways that honors individuals' perspectives on their health care, treatment, and relationships with providers. It may also mean the adoption of new organizational processes to teach individuals the skills to manage their conditions and health over time and to collaborate with their health care providers to make decisions about their care. Self-management support also involves actively engaging a client's natural supports who can play a positive, but nonprofessional, role in recovery.¹⁴

Delivering self-management support and promoting recovery will require behavioral health organizations and other stakeholders to re-organize care processes and care delivery systems. Within any organization, this is likely to involve changing organizational cultures and setting new role expectations and service priorities. Behavioral health organizations can anticipate needing to innovate, acquire external support, dedicate time and resources, and commit to effect change and achieve this vision of person-centered and integrated care.

This assessment tool was developed as a resource for prevention, treatment and recovery services. It aims to help service leaders, providers, and administrators in organizations that serve individuals with serious mental illness or substance abuse conditions to:

- Raise awareness of the features of client-provider interactions and care processes consistent with self-management support in your organization.
- Provide a 'blueprint' to assess self-management support activities in your organization.
- Highlight examples your organization may consider to expand your capacity to integrate support for self-management.

Using This Tool*

For the most comprehensive assessment of your organization, the following method is recommended:

1. This tool should be completed by at least two staff within your organization. Staff members should score each element as they go through the tool. The total time for completion will vary; however each user should expect to spend 1-2 hours completing the tool. A tally sheet is provided to add up the final scores.
2. Identify several people with different perspectives such as clinical and support staff, clients, peer supports and administrators to complete the tool. It is important to include multiple points of view.
3. Ask each person to review the elements of self-management support (Sections 1 and 2) independently. Give the following instructions.
 - a. “You should consider the prior three-month period of care delivery and the clients you or your care team served when answering the questions.
 - b. Choose one response for each question.
 - c. There is no right or wrong answer. Please make your best guess.
 - d. Complete the tally sheet.”
4. Use the instructions to interpret each individual’s total score.
5. Convene the staff completing the tool or a slightly larger team to discuss the scores. This may be an opportunity to ask more questions and identify activities that are going well, as well as identify opportunities for improvement. The scores may help your organization set priorities for improving self-management support services.
6. Refer to the tool or a subsection of the tool with the same or different individuals to monitor your organization’s progress over time. Revisiting the tool every six months or so may help maintain your organization’s commitment to change.

Your organization will likely use other resources to help with strengthening self-management support, such as colleagues, practice coaches, experienced providers, consultants, and additional tools. You might explore:

- SAMHSA’s Recovery to Practice website at <http://www.samhsa.gov/recovery-to-practice>
- AHRQ self-management area at <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/self/index.html>

* It is not a requirement of any programs sponsored by the Centers for Medicare & Medicaid Services (CMS) to assess your organization with this tool.

Section 1: Self-Management Support Foundations

1.1 Activating Clients to Engage in Self-Management

In person-centered care delivery, providers can help prepare and support clients in managing their own health by increasing clients' knowledge of and confidence in engaging in healthy behaviors. Providing information and encouragement is a crucial step that will support clients in managing mental illnesses or substance abuse and ensure that their natural supports are full partners in the care and recovery processes. Supporting clients to take active roles in their own care is central to their recovery and increases care integration and coordination to meet clients' needs and goals. This support includes offering a range of options that facilitate meaningful choices by clients as well as access to care and medical records. Emphasizing the central role that clients play in their care decisions will promote collaboration between providers and clients

» 1.1.1 Do staff and providers communicate with clients in a manner that promotes and maintains dignity and respect?

Communicating with dignity and respect includes acknowledging that clients manage their own lives and health conditions, even when they are facing difficulties. Providers and staff should demonstrate respect when communicating with clients by using non-judgmental language and ensuring client privacy. This is particularly true for individuals with the extra stigma of addiction, in addition to mental illness. A first step in maintaining the dignity of clients is to elicit their values, preferences, and needs.

Examples

- Train staff to use non-judgmental language when communicating with clients (e.g. emphasizing acceptance, genuineness, and empathy in communications; saying “yes, and” instead of “yes but” and avoiding words such as “never” and “should.”) Sensitivity to language choice is particularly important when inquiring about alcohol and drug use patterns.
- Offer private places to discuss care concerns or schedule appointments.
- Ask clients and their natural supports about their experiences with providers and staff, and offer opportunities for anonymous feedback.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.1.1 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

» 1.1.2 Do staff and providers offer clients and their natural supports meaningful choices among an array of options?

Meaningful choices in care include choosing their providers or care team members and deciding the time and place of their care. This also includes offering a range of prevention, treatment and recovery support options and interventions (e.g., choice of medications, group or individual support, cognitive behavioral therapies, supported education, supported

employment), as well as implications of their choices (e.g., expected clinical outcomes, expected side-effects of medications, insurance coverage).

Examples

- Provide clients with guidelines for optimal care and options for therapeutic interventions at the appropriate literacy level and in the appropriate language.
- Provide suggestions about how to obtain desired services that may not be covered under insurance.
- Offer decision tools about therapeutic choices with client stories to help clients understand choices.
- For individuals or families with alcohol or drug issues, provide referrals to peer support options such as Twelve Step programs, which include Alcoholics Anonymous and Narcotics Anonymous as well as Al-Anon for families and friends of alcoholics or addicts, or the cognitive-behavioral based SMART (Self-Management And Recovery Training) recovery program.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.1.2 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

» 1.1.3 Do staff and providers invite clients and their natural supports to actively participate in care planning and self-management?

Evidence suggests that people are more likely to adhere to and derive optimal benefit from those treatments and care plans that they help plan and implement. Dispelling the notion that “the doctor always knows best” can help clients and their natural supports appreciate the expertise they bring to the care and recovery process.

Examples

- Emphasize the essential and active roles that clients and natural supports have to play in the care and recovery process.
- Emphasize the importance of clients and their natural supports learning about options and collaborating on treatment decisions.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.1.3 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

» 1.1.4 Does the organization provide multiple or easy opportunities for clients to contact their team?

Allowing clients simple and convenient access to their care team helps encourage communication and reduces barriers to self-management. At a minimum, clients should have easy access to their care teams by telephone. Some providers may choose to utilize mobile phone applications or other communication channels requiring internet access.

Examples

- Name a staff contact person and provide a telephone number for emergency access. If regular client access to a telephone is an issue, provide assistance in getting free or low cost phone service (e.g. lifeline cell phone services offered in some states).
- Consider developing a secure patient portal and offer email access to the care team to streamline and facilitate communication.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.1.4 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

» 1.1.5 Do staff and providers elicit and document client preferences for ongoing care and communication?

Client preferences should be documented, and follow-up care should be customized to meet client needs as well as communicated in a mode that is preferred by the client (i.e. phone, in-person, email) to the greatest extent possible.

Examples

- Provide care preference choices in a visit preparation guide or client orientation tool.
- Document care preferences in a client’s chart or electronic profile.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.1.5 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

» 1.1.6 Do clients have access to their own health information?

Access to their own health information, including their self-management goals and any ongoing treatment and recovery support plans, helps support client engagement and simplifies coordination across providers. At a minimum, clients should have access to their information in paper form. Clients should also be able to designate proxies or natural supports that can have access to their health information, as they deem necessary. Providers need to be sensitive to the impact that health information might have on clients with serious mental illness or addictive disorders and allow time to review and explain such information.

Examples

- Supply medication records for clients to carry with them.
- Document self-management goals and action plans in the client record.
- Explain to clients how to request copies of their medical records and provide them with the name and phone number of the person and/or department that handles records requests.
- Offer printed visit summaries at the end of every visit.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.1.6 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

1.2 Self-Management Support and Care Planning

A key component of self-management support for an individual with serious mental illness or addictive disorders is care planning guided by the person's hopes and life goals. The symptoms and effects of an individual's mental illnesses or addictive disorders are challenges to reaching their goals. Care planning in self-management support helps the care team, clients, and their natural supports focus on interventions to manage symptoms while supporting clients in pursuing their self-identified goals. While it is typically the client who works with one staff member in particular—such as a primary clinician, nurse, social worker, or peer specialist—to develop the plan, the entire care team should be available for the planning meeting so that short-term objectives and the respective roles of each person involved are clear.

» 1.2.1 Do staff and providers elicit clients' understanding of their health conditions early in care?

Discerning the client's own understanding of his or her situation and health status lays the foundation for providers to share information in an accessible and responsive way. While doing so the provider can identify client strengths which can contribute to planning for and pursuing recovery.

Examples

- Ask clients, "What is your understanding of the situation?"
- Ask clients and their natural supports about their own beliefs about and attitudes towards mental illness and substance use.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.2.1 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

» 1.2.2 Do staff and providers elicit clients' concerns related to the experiences of mental illness and addiction disorders?

Providers should ask the client and natural supports about circumstances leading up to the client presenting for care, as well as their experiences with the behavioral health condition or issue. Providers should also ask the client and natural supports what they consider to be their most pressing concerns or needs, including basic needs such as housing, income, employment, social isolation, or other medical conditions.

Examples

- Ask “What experiences have you had that led you to seek care?” or “What are your most pressing concerns and needs right now?”
- Use a visit preparation form or include questions about client experiences on an intake form to remind staff to ask about these concerns.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.2.2 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

» 1.2.3 Do staff and providers assess what clients and their natural supports have tried and are currently doing to manage the condition?

Understanding what is working and what is not working for clients enables providers and clients to identify strengths, and can open a discussion that identifies areas for empowerment and skill building to meet clients' goals.

Examples

- Include questions about previous experience as part of a visit preparation form.
- Ask, “What has worked for you in the past?” or “How have you been managing your conditions or symptoms?”

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.2.3 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

» 1.2.4 Do staff and providers explain the care planning process to clients to support self-management and recovery?

Care planning helps providers and clients focus on actions, treatments, and other interventions to manage symptoms and reach the individual's goals. Concrete explanations of how the team will collaborate with clients and their natural supports to address goals and how the planning process will occur (e.g., time, place, composition of team) are helpful.

The roles of the client, the natural supports, and the care team in addressing and accomplishing goals should also be established.

Examples

- Explain how life goals can be motivators to support healthy behaviors and can be broken down into short-term objectives so individuals and providers can track progress and make changes as needed.
- Provide sample care plans and connect clients and their natural supports with peer supports who can help them understand the care planning process.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.2.4 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

» 1.2.5 Do care planning sessions include clients and their natural supports?

Providers often need to offer evening and weekend hours to accommodate the schedules of clients or their natural supports who work or attend school; this maximizes the opportunity for a client’s natural supports to attend planning meetings. When individuals are being prescribed medications, planning sessions with both the client and his or her natural supports can provide the care team with otherwise unavailable information about medication compliance and response. This is particularly important for individuals being treated with detoxification medications or controlled substances.

Examples

- Offer planning meetings after hours and offer virtual or telephone meetings if necessary to accommodate schedules.
- Offer planning meetings at community sites convenient to clients and their supports.
- Encourage clients to bring natural supports to planning meetings if they choose.
- Discuss the effects of medications and other treatments on activity and functional level with both the client and their natural supports.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.2.5 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

» 1.2.6 Do staff and providers offer accurate information in a way that is accessible and culturally responsive?

Information empowers clients to manage their illness and symptoms. A person-centered approach conveys information to clients and their natural supports that is consistent with their ethnic/racial/cultural background and affinities, their

levels of literacy and education, and their initial understanding of the situation. Presenting information in this manner shows respect and instills hope.

Examples

- Ask clients’ preferences for receiving information and train staff to tailor delivery to clients’ preferences.
- Speak with clients in their primary language or use educational brochures, DVDs, or websites in the appropriate language or featuring persons from similar cultural backgrounds.
- Within the bounds of privacy regulations and the clients’ wishes, connect clients and their natural supports to community leaders and peer supports they can trust to effectively offer culturally responsive information.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.2.6 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

» 1.2.7 Do staff and providers address internalized stigma and stigma from the community?

Clients and their natural supports may know little about mental illness or substance abuse conditions when they initially present for care. In addition, they may have preconceptions of these conditions that create a negative impact on their ability to manage them. This lack of knowledge and self-stigma is often confounded by stigma in the minds of many persons in the community. Addressing a client’s understanding of their diagnosis as well as addressing stigma from the community is often an important step in empowering them to manage their illness.

Examples

- Provide free educational materials on mental illness and substance abuse from the Substance Abuse and Mental Health Services Administration (SAMHSA) for both clients and their natural supports.
- Give information on outcomes in mental illness and substance abuse and examples of persons with these conditions who have led gratifying lives to increase clients’ and their natural supports’ confidence to manage their illness.
- Link family members and significant others with local support groups such as the NAMI Family-to-Family Education Course.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.2.7 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

» 1.2.8 Do staff and providers elicit client’s life goals?

Providers encourage and support clients to identify realistic life goals and build bridges between these goals, their goals for their health and wellness, their care choices, and the roles that clients and their natural supports need to play in promoting self-management and recovery.

Examples

- Ask questions such as, “What is important to you? For example, your ability to keep working, to play with your grandchild, or to travel?”
- Train staff in motivational interviewing to elicit client goals, barriers, and problem solving techniques.
- Document goals in medical chart or electronic record.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.2.8 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		Yes No

» 1.2.9 Do staff and providers collaborate with clients and their natural supports in articulating short-term objectives consistent with client life goals?

Formulating short-term objectives will move clients towards their life goals in ways that are observable, measurable, and achievable within a specified timeframe (e.g., three months). These objectives build on the person’s and their natural supports’ strengths, are tied to care, and specify action steps that help people know what to do to manage illness and pursue recovery. Providers and clients can work together in identifying their internal strengths, interests, and resources (e.g., a love of music, an aptitude for electronics). Identifying strengths and resources can be linked to meeting short-term goals and documented in action and care plans.

Examples

- Ask what has worked in making changes in the past.
- Use available resources such as the Wellness Recovery Action Plan (WRAP) or other evidenced-based practices to facilitate discussions with clients.
- Assess barriers and facilitators to goal attainment including the client’s needs related to income, transportation, communication tools, culture, and social environment.
- Check clients’ confidence level on the action plan before closing.
- Explore accommodations that might be required for successful implementation of the action plan (e.g., setting alarms on cell phone to remind the client to take medication).

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.2.9 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		Yes No

» 1.2.10 Do staff and providers teach clients concrete problem solving or coping skills?

Self-management will require clients to use problem-solving and coping skills to manage their illnesses and everyday lives. Staff and providers should include a discussion of these skills as part of the care planning process to prepare clients and their natural supports for unanticipated challenges they may encounter.

Examples

- Provide clients and natural supports with a brochure or print-out with key steps for problem solving and coping with difficult situations.
- Provide examples of situations, such as managing side effects from treatment, in which a client may need to use problem-solving or coping skills.
- Refer clients to the Hungry, Angry, Lonely, Tired (HALT) model for controlling stress and cravings, which teaches clients to respond to these needs with food, talk, companionship, and sleep rather than drug or alcohol use.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.2.10 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p style="text-align: center;">Yes</p> <p style="text-align: center;">No</p>

» 1.2.11 Do staff and providers assist clients in identifying both personal and community resources to support healthy choices across various life domains?

Ideally, care plans will not be limited to symptom reduction/elimination or the remediation of deficits, but will include a broad array of interventions and action steps that support the person across various life domains.

Examples

- Discuss medical history and how clients or their natural supports may conduct research about alternative approaches.
- Link clients with primary health care providers and specialty health care services.
- Identify resources readily available in the client’s social environment such as support for the person to attend school, financial resources, and self-help programs that support managing illness and reaching goals. The Twelve Step programs, such as Alcoholics Anonymous, or cognitive-behavioral programs, such as SMART Recovery, are free community based peer support groups. Behavioral health providers can encourage attendance of these programs to educate clients about alcohol and drug issues. These groups provide both free and low cost literature at their meetings.
- Document what resources are being used by clients and their natural supports and discuss how these resources have been helpful during care planning meetings.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.2.11 Score	This a priority for my organization

<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p style="text-align: center;">Yes</p> <p style="text-align: center;">No</p>
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» 1.2.12 Is peer role modeling of self-management offered in natural settings?

A key component of promoting self-management is role modeling by peer support staff (e.g., “coaches” or “mentors”), by peer support groups, or in self-management workshops. Role modeling and practicing self-management tasks in natural environments are more effective in promoting self-management than providing teaching and tools alone. Peer role modeling in the Twelve Step tradition for addiction recovery involves a sustained relationship with a more experienced member, termed a sponsor.

Examples

- Model the practice of self-managing actions. This may be an especially appropriate role for a peer member of the care team.
- Provide venues for support groups that help to role model and promote self-management such as recovery community organizations and recovery community centers.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.2.12 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p style="text-align: center;">Yes</p> <p style="text-align: center;">No</p>

» 1.2.13 Are point-of-care reminders available to prompt providers to address self-management follow-up or ongoing care issues during visits?

At a minimum, flags should be included in paper charts to alert members of the care team when a client should be monitored following a particular therapy or self-management action.

Example

- If available, use an electronic system (EMR or registry) with the ability to alert providers (e.g., electronic flags, pop-up reminders) to clients who need follow-up related to a self-management goal or activity.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.2.13 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p style="text-align: center;">Yes</p> <p style="text-align: center;">No</p>

» 1.2.14 Are providers and other staff familiar with a wide array of community resources?

To contribute to the development of a broad care plan that will address all major aspects of a client’s life, it is useful for some of the staff to be familiar with available community resources to offer the client relevant opportunities and provide support in accessing these opportunities (e.g., a bowling league that is recruiting new members, an AA club that sponsors sober dances, community health fairs, etc.).

Examples

- Search for local events sponsored by the National Alliance on Mental Illness (NAMI) as well as sober activities sponsored by Alcoholics Anonymous, SMART Recovery, recovery community organizations, and recovery community centers.
- Develop relationships with community programs to tailor to client needs and attend service provider meetings offered in your community.
- Identify names and numbers of contacts in these organizations to provide a “warm handoff” to clients.
- Employ an intern, a volunteer, peers, or natural supports to develop local resource guides to share with clients including culturally relevant resources in literacy appropriate formats.
- Create a resource list with requirements and procedures for relevant local community organizations, including contact names and numbers for referral.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.2.14 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

1.3 Supporting Self-Management with Care Teams

Clients and their natural supports benefit from services that range from medical care and home health services to supported housing, supported education or employment, and peer support. A care or recovery team can best provide the range of services and often includes providers from different disciplines and settings, clients, and natural supports. The care team may also partner with outside organizations and can help clients and their supports coordinate the range of medical care and other services to meet the client’s goals.

Connecting clients and their natural supports to designated members of the care or recovery team is important so that all parties know *who* must do *what*, and *when* to work toward short-term objectives. Ongoing communication and collaboration among the members of this team, outside of periodic and more formal care planning discussions, can provide essential cohesion and avoid care that is not aligned with clients’ goals. Establishing roles and training staff to participate in care teams to support self-management is a key organizational activity.

» 1.3.1 Are care teams comprised of health care providers, peers, the client, and the client’s natural supports?

Clients who self-manage mental illness or substance abuse benefit from the assistance of a variety of health care providers and other supports. The core care team may include primary care practitioners, recovery support workers,

social workers, psychologists, addiction counselors, occupational therapists, psychiatric rehabilitation practitioners (e.g., residential staff, job coach), navigators, care coordinators, case managers, and peer support providers*, as well as the clients and their natural supports. The core team considers the information that may be useful for other providers caring for the client.

Examples

- With the client’s consent, reach out to social workers, home health aides, and other natural supports in the client’s life (e.g., family members, athletic coach, landlord).
- Provide information on peer support groups and online support groups that can offer clients the support and knowledge that can only be provided by others living with similar conditions.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.3.1 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

» 1.3.2 Do care teams explain to clients and their natural supports the roles for team members, including the client and natural supports roles?

Many clients may not be familiar with a team approach to care and explaining that more than one person is available for support may empower greater connection between clients and provider teams. The role of the provider includes equipping clients and their natural supports with the knowledge, skills, and supports needed to self-manage. Providers can also emphasize that the client is a team member with a critical role.

Examples

- Provide a letter or team care brochure explaining who team members are and how they communicate.
- Do a “warm handoff” whenever possible to introduce the client to another team member during a visit.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.3.2 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

* Peer support providers are being used increasingly in behavioral health care for a variety of purposes, including engagement, advocacy, mentoring, coaching, and—of particular importance here—role modeling self-management. See #3.4. below.

» 1.3.3 Does the care team regularly acknowledge accomplishments and review and adjust the care plan to ensure adequate support to clients and their natural supports?

Acknowledging accomplishments and milestones is an important step in the care planning process. Ongoing follow up to assess and problem solve with clients and their natural supports is also a critical function of the care team. Care or recovery planning meetings should occur regularly (at a minimum every three months) to respond to clients' needs. Updates to care plans can be made during in-person visits, after home visits, or during phone calls with clients.

Examples

- Provide protected time and space for regular care team meetings. Some providers hold weekly or daily meetings with provider care teams to ensure shared updates, and others use electronic communication.
- Document care planning either in a highly structured way, such as a care plan template, or more flexibly, such as color coding on a paper chart.
- Advise staff to acknowledge successes or milestones and to help clients see problem-solving as a normal activity and not an indication of failure.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.3.3 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

» 1.3.4 Is a care team member designated to follow up with clients and their natural supports?

Designating a care team member to follow up with clients and their natural supports will facilitate coordination of care with providers and other community-based services. Training staff in basic motivational interviewing skills may enhance follow-up with clients and their natural supports.

Examples

- Identify and document the best way to reach and communicate with clients, whether it is by phone, email or regular in-person visits.
- Communicate care plan changes and updates for continued focus of the care team on clients' goals.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.3.4 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

>> 1.3.5 Are support referrals coordinated, tracked and communicated with outside providers, case managers and organizations in the community?

Ensure electronic systems are in place to track referrals to simplify coordination and monitoring. At a minimum, use a paper-based system to track the services that are being used. Designate staff to complete follow-up to ensure clients are accessing appropriate services. Clients may have case managers in their health plan or another social service agency.

Examples

- Develop enrollment systems (either phone-based or online) for clients to take advantage of existing programs.
- Establish a designated person at community sites who will connect with referrals from your organization.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	1.3.5 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

Section 2: Monitoring Self-Management Support Activities

Ongoing monitoring is needed to ensure that your organization’s staff or care teams continue to meet clients’ needs and provide the necessary follow-up to help clients achieve and maintain health. Collecting and assessing feedback from persons with behavioral health and substance abuse conditions as well as their natural supports improves the quality and responsiveness of care. New roles for staff will include organizing and using information and data from clients and their natural supports for monitoring and program improvement. Data systems can simplify the process for ongoing monitoring, but organizations can start with low-tech activities to assess whether self-management support and recovery activities are occurring for the majority of their clients. Leaders may need to assign responsibility and enable staff to function in these roles.

» 2.1 Is a formal feedback mechanism available for clients and their natural supports to comment on their care and help make improvements in your organization?

Feedback from clients and their natural supports should address the quality, appropriateness, and experience of the care they receive. Ideally, feedback is requested in a timely manner and includes the use of focus groups, interviews, surveys or other means to capture client input. Let clients know that feedback about changes in care delivery processes is valued, and describe how it is used to make substantive changes.

Examples

- Gather client feedback through client experience surveys or comment cards.
- Conduct client walkabouts, documenting client feedback as they experience an in-person visit, home visit, or other encounter with staff at your organization.
- Involve clients and their natural supports in developing surveys and other feedback mechanisms.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	2.1 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p>Yes</p> <p>No</p>

» 2.2 Is input on program and staff activities sought from the client and their natural supports?

Client and natural support input can be sought at all levels of program operation, including policy and program design, monitoring and evaluation, and performance improvement initiatives.

Examples

- Include clients and their natural supports on governing or advisory bodies, quality improvement teams, agency committees, and work groups.
- Involve them in developing information resources and tools, such as new client orientation guides.
- Document preferences and suggestions in the client’s chart or electronic record.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	2.2 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p style="text-align: center;">Yes</p> <p style="text-align: center;">No</p>

» 2.3 Are reports and feedback on care and self-management support activities available to providers in a timely manner for ongoing quality improvement purposes?

Care teams require ongoing information about their clients to assess the consistency and effectiveness of their actions. This information is also needed to compare their performance with peers to support the sharing of best practices.

Examples

- Review ten care plans over the prior three months and report to care teams. Review documentation to confirm client involvement in care planning or follow-up on short-term objectives.
- Track how often care plans are made and the follow progress of clients toward meeting their goals.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	2.3 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p style="text-align: center;">Yes</p> <p style="text-align: center;">No</p>

» 2.4 Are provider-level or care team data reports generated and tied to guidelines or care plans to support self-management and care?

Ideally, providers and care teams should be able to quickly assess which clients need follow-up and reminders. Provider-level reports are critical tools to allow providers to effectively manage groups of clients. They can be generated from existing electronic systems to assist providers in directing their efforts to those clients who need it most. If data reports are not easily accessible through existing electronic systems, organizations may use a report generation module for developing client-level reports.

Example

- Use an electronic registry or database to sort clients by their care team and to identify which clients have outstanding follow-up steps. These modules can be built into external registry systems or through databases or tracking systems.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	2.4 Score	This a priority for my organization

<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p style="text-align: center;">Yes</p> <p style="text-align: center;">No</p>
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» 2.5 Does the organization have a team that leads QI activities focused on self-management support?

A dedicated QI team ensures appropriate projects are being initiated, metrics are being monitored and shared with providers, and projects and their metrics are discussed across the organization. Leadership must provide organizational support and dedicated time for team members to focus on these activities.

Examples

- Create a QI team with provider, clinical support, program manager, and IT staff when available. Ideally the team should include clients and their natural supports.
- Support clients and natural supports by involving multiple clients in QI activities, so that their level of representation is comparable to that of staff.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	2.5 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p style="text-align: center;">Yes</p> <p style="text-align: center;">No</p>

» 2.6 Does the organization provide opportunities for staff training in QI?

Build QI expertise by offering trainings or participating in collaborative QI projects that focus on measurement and use of data to drive clinical and operational changes.

Examples

- Use resources from organizations that offer tools for health care professionals, such as the Institute for Healthcare Improvement.
- Hire QI consultants to help coach teams to build the necessary skills for developing metrics and for effectively using data to drive improvements.
- Support clients and natural supports by providing orientation to concepts and QI terms to ensure understanding and reporting of their input. Even if a recommendation is rejected or delayed, let them know the response to their input.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	2.6 Score	This a priority for my organization

<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p style="text-align: center;">Yes</p> <p style="text-align: center;">No</p>
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>> 2.7 Does the organization have a formal means for sharing the results from QI initiatives?

Share data at the care team level and with clients and their natural supports to ensure continual improvement and sharing of best practices. Regular data sharing across teams can help motivate interest in improving care and facilitate the sharing of promising practices.

Examples

- Discuss data at regular meetings and consider linking results to performance reviews and incentives for the organization.
- Post paper graphs or dashboards on the clinic walls so that providers, clients, and natural supports can view the performance and goals of the organization.

How often does this element occur?	Are there policies in place and staff trainings available for this element?	Does the organization consider client feedback on this element?	2.7 Score	This a priority for my organization
<ul style="list-style-type: none"> ▪ Usually (2) ▪ Sometimes (1) ▪ Never (0) 	<ul style="list-style-type: none"> ▪ Organizational policy AND staff training (2) ▪ Organizational policy OR staff training (1) ▪ None (0) 	<ul style="list-style-type: none"> ▪ Yes (1) ▪ No (0) 		<p style="text-align: center;">Yes</p> <p style="text-align: center;">No</p>

Tally Sheet

SECTION 1	
Element	Score
1.1.1	
1.1.2	
1.1.3	
1.1.4	
1.1.5	
1.1.6	
1.2.1	
1.2.2	
1.2.3	
1.2.4	
1.2.5	
1.2.6	
1.2.7	
1.2.8	
1.2.9	
1.2.10	
1.2.11	
1.2.12	
1.2.13	
1.2.14	
1.3.1	
1.3.2	
1.3.3	
1.3.4	
1.3.5	
TOTAL	

SECTION 2	
Element	Score
2.1	
2.2	
2.3	
2.4	
2.5	
2.6	
2.7	
TOTAL	

Interpreting your Score

Tally total scores separately for each individual who completes the tool. Also tally scores from Section 1 and Section 2 separately. The following scale may offer your organization some guidance in assessing its capacity for self-management support and monitoring your program.

SECTION 1: Self-Management Support Foundations

81-125

Your organization has a strong foundation for self-management support. Consider which of the lower scoring elements best align with your organizational goals to determine feasible and appropriate next steps for your organization. Review the examples in the lower scoring elements for steps or processes your organization may wish to implement.

41-80

Your organization has some of the necessary foundational elements for self-management support. Consider what foundational elements (section 1) best align with your organizational goals to determine feasible and appropriate next steps for your organization. Review the examples in the lower scoring elements for steps or processes your organization may wish to implement. You may also consider activities that may be implemented to monitor your organization's progress (section 2).

0-40

Your organization needs to build a foundation for self-management support. Consider the overall importance of self-management to the needs of your clients and how self-management may fit with your organizational procedures. Review the examples in the lower scoring elements for steps or processes your organization may wish to implement. In addition, review the foundational elements (section 1) and consider what may be appropriate and feasible to implement in your organization in the short- and long-term.

SECTION 2: Monitoring Program Data

24-35

Your organization has a strong foundation of procedures to monitor its activities. Consider which of the lower scoring elements best align with your organizational goals to determine feasible and appropriate next steps for your organization. Review the examples in the lower scoring elements for steps or processes you may wish to implement.

13-23

Your organization has some foundational elements and procedures to monitor its activities. Review the examples in the lower scoring elements for steps or processes you may wish to implement to help monitor your organization's efforts in establishing self-management support. In addition, consider which foundational

elements (section 1) best align with your organizational goals to determine feasible and appropriate next steps for your organization.

0-12

Your organization needs to improve or create procedures to monitor your activities. Consider the overall importance of self-management to the needs of your clients and how monitoring may fit with your organizational procedures. Consider what may be appropriate and feasible to implement in your organization in the short- and long-term. Review the examples in the lower scoring elements for what steps or processes your organization may wish to implement.

Tools and Resources

Several tools and resources are included below. They are organized into the following categories: “Implementation Resources for Organizations,” “Approaches to Supporting Self-Management for Individuals with Serious Mental Illness,” “Training for Clinicians Delivering Self-management support,” and “Tools to Assist Consumers in Self-Management: Problem-solving, Skill Building, and Goal Setting.”

Implementation Resources for Organizations

States Where Peer Support Services Are Reimbursable Under State Medicaid Plans

This resource includes a list of states where peer support services are reimbursable under state Medicaid plans. This resource can be used by behavioral health organizations or states considering the use of certified peer specialists reimbursable under Medicaid to provide self-management services to their patients.

<http://www.power2u.org/downloads/PillarsOfPeerSupportServiceReport.pdf>

Health Promotion Programs for Persons with Serious Mental Illness: What Works? A Systematic Review and Analysis of the Evidence Base in Published Research Literature on Exercise and Nutrition Programs

This review authored by Dr. Stephen Bartels can be used by behavioral health organizations and providers to understand the effectiveness of physical activity and nutrition interventions for persons with serious mental illness and provides recommendations (e.g., program duration).

<https://niatx.net/pdf/wicollaborative/HealthPromoSML.pdf>

Illness Management and Recovery (IMR) Evidence-Based Practices Kit

The IMR Evidence-Based Practices Kit issued by public officials, program leaders, mental health center administrators, and mental health practitioners in developing illness-management and recovery mental health programs that emphasize personal goal-setting and actionable strategies.

<http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463>

Peer Support among Persons with Severe Mental Illnesses: A Review of Evidence and Experience

This review authored by Larry Davidson of Yale University’s Program for Recovery and Community Health in the School of Medicine can be used by practitioners seeking to use peer support as this review discusses common barriers and concerns program leaders have with respect to peer support and effective strategies for implementing peer services for persons with severe mental illness.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3363389/?tool=pubmed>

Approaches to Supporting Self-Management for Individuals with Serious Mental Illness

What To Expect When You're Self-Managing: A Client Handout For Behavioral Health Providers

This client handout is designed to support your conversations with clients on the self-management of chronic conditions. It includes information on the purpose of self-management; what the client should expect from his or her care team; what the client may ask for from natural supports; and resources available to support his or her efforts to self-manage.

https://resourcesforintegratedcare.com/behavioral_health/self_management_support/client_handout

Partnering in Self-Management Support: A Toolkit for Clinicians by the New Health Partnerships

This resource developed by the Institute for Healthcare Improvement (IHI) can be used by organizations implementing self-management support programs using the tools and examples enclosed in this toolkit.

<http://www.ihl.org/knowledge/Pages/Tools/SelfManagementToolkitforClinicians.aspx>

Provider Manual for the Diabetes Literacy and Numeracy Education Toolkit

This toolkit is a compilation of training and patient care tools developed by the Vanderbilt Diabetes Research and Training Center for healthcare professionals to use to improve the educational interactions between diabetes providers and their patients.

<http://www.mc.vanderbilt.edu/documents/CDTR/files/dlnet-instructions%5B1%5D.pdf>

Training for Clinicians Delivering Self-management Support

Self-Management Video

This video developed by the Improving Chronic Illness Care (ICIC) Foundation can be used to teach clinicians to assist patients in goal-setting, creating an action plan, and problem-solving to overcome self-management barriers.

http://www.improvingchroniccare.org/index.php?p=See_How_Planned_Care_Works&s=225

Video on Collaborating with Patients

This video developed by the California HealthCare foundation's Team Up for Health Initiative discusses how to develop an action plan to support healthy behavior change to support medication management.

<http://www.chcf.org/publications/2008/08/video-on-coaching-patients-for-successful-selfmanagement>

Video on Techniques for Effective Patient Self-Management

This video developed by the California Healthcare Foundation teaches clinicians basic strategies to help patients choose healthy behaviors and transform the patient-provider relationship.

<http://www.chcf.org/publications/2006/08/video-with-techniques-for-effective-patient-selfmanagement>

Wellness Trainings

This resource collection from the SAMHSA-HRSA Center for Integrated Health Solutions includes links to tools and guides focused on wellness.

<http://www.integration.samhsa.gov/health-wellness/wellness-strategies>

Motivating Change Online Programs

These online programs have been created by Kaiser Permanente Regional Health Education Online Learning. These modules address medication adherence, brief negotiation, and chronic conditions including diabetes, hypertension, congestive heart failure, and asthma.

<http://kphealtheducation.org>

Tools to Assist Consumers in Self-Management: Problem-solving, Skill Building, and Goal Setting

Action Plan Selection Guide - A Tool For Self-Management Support

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

https://resourcesforintegratedcare.com/behavioral_health/self-management_support/tool/action_plan_guide

Self-Management Success Story Handouts

The six client handouts below feature the success stories of individuals who have used self-management techniques to effectively manage their behavioral health and substance use conditions. The self-management success story handouts are available in English and Spanish.

<https://resourcesforintegratedcare.com/concept/client-handout/2016/self-management-stories>

Wellness Recovery Action Plan (WRAP) Program

The WRAP program developed by Mary Ellen Copeland at the Copeland Center can be used by adults to self-manage their illness.

<http://wrapandrecoverybooks.com/store/>

Illness Management and Recovery (IMR) program

Illness Management and Recovery (IMR) program increases consumer ability to problem solve, manage illness and pursue personal recovery goals.

<http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463>

Chronic Disease Self- Management Program (CDSMP)

The Chronic Disease Self-Management Program (CDSMP) developed by Stanford University can be used by adults with chronic conditions (including SMI) who participated in a six week intervention that is led by a master trainer or leader who has undergone the CDSMP training.

<http://patienteducation.stanford.edu/training/>

Report Card Tool

This tool developed by the Greater Nashua Mental Health Center is used by clinicians and consumers to begin discussions about physical health and patient goals and track health and goals over time.

Appendix C,

<https://www.resourcesforintegratedcare.com/sites/default/files/Approaches%20to%20Supporting%20Self-management%20for%20Individuals%20with%20SMI.pdf>

Integrated Wellness Plan

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.

Appendix B,

<https://www.resourcesforintegratedcare.com/sites/default/files/Approaches%20to%20Supporting%20Self-management%20for%20Individuals%20with%20SMI.pdf>

Whole Health Action Management (WHAM) Action Plans

WHAM action plans can be used by consumers to add their goals (including completion date) and 8 weekly action plans to reach goals (includes a confidence scale score).

<http://www.integration.samhsa.gov/health-wellness/wham>

Wellness Recovery Action Plan (WRAP) Blank Action Plan

The WRAP action plan developed by Mary Ellen Copeland at the Copeland Center can be used by adult patients/consumers to monitor, reduce and eliminate uncomfortable or dangerous physical symptoms and emotional feelings by completing a workbook identifying triggers, responses to these triggers, and crisis plans.

<http://namiaustin.org/wp-content/uploads/2014/09/Developing-a-WRAP-Plan.pdf>

Tool Development

The model of self-management described in the Tool was derived from the experience of behavioral health clinicians, primary care clinicians, and individuals with expertise in implementing self-management support. These individuals collaborated to describe program elements and activities that, if adopted by an organization, provide state-of-the-art recovery and self-management support services as well as quality improvement processes. Drafts of this tool were shared with leading behavioral health organizations, and their feedback on the content and format was incorporated.

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Dr. Davidson is the Director of the Yale University Program for Recovery and Community Health. He brings tremendous knowledge of the evidence base supporting recovery-oriented services and self-management among persons with mental illness. He also has extensive experience in transforming systems of behavioral health care to engage persons with behavioral health conditions and their support system as partners in the process of integrating the concepts of recovery and person-centered care throughout all services and supports.

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