HARMONIZED HEALTH

Interim Evaluation Report

February 2021

ThreeHive CONSULTING

Table of Contents

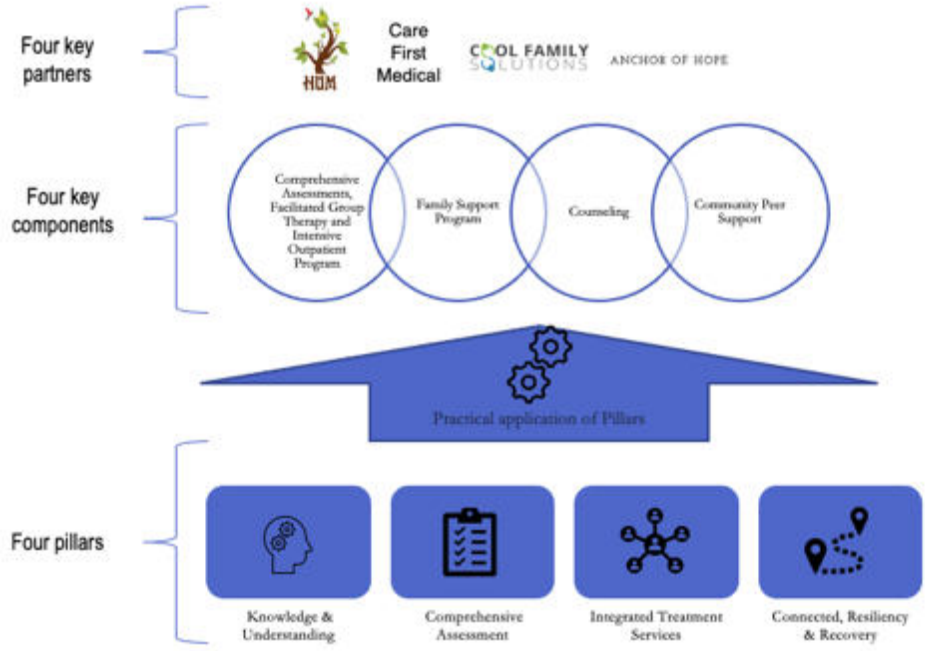
Executive Summary

Jesse Braden Titus "Braden" died tragically from suicide after not receiving the mental health care he needed in the weeks leading up to his death. In 2016, Braden's family established the Thumbs Up Foundation (TUF). One of the feature initiatives of TUF is the Harmonized Health Program (HH). HH is intended to be a new, different and more effective way of supporting people with mental health and addiction challenges. HH aims to provide seamless, integrated care that puts people (as opposed to the system) first.

Early in the program, HH hired evaluation support to a) define HH's model, and; b) measure how effective the model is in supporting people with mental health and addiction challenges. HH is at its halfway point. As such, this interim evaluation report focuses on defining and describing the model and to what extent it has been adopted in the first six months. Early outcomes are also reported; however, these will be reported on fully in the final report (August 2021).

The Harmonized Health model

The HH program has designed a community addiction and mental health model designed around four key pillars. Those pillars are operationalized by four partner organizations, delivering four key components (illustrated below).



A major focus of HH's work to date has been focusing on how to support integration of service providers. HH has conducted various training, including program, clinical and community supports training. HH has trained 20 people (i.e., operation team members, service providers and volunteers) and plans to continue training 16 people by the end of the program. The number and extent of training that is conducted is largely contingent on funding.

Adoption of the model

The number of clients that participate in HH is also contingent on funding. The HH program has funding for 12 individuals to participate; however, the model has been adopted by more people. Prior to the HH program's official start, in August 2020, clients were receiving various aspects of the HH model. In addition, HH has recently onboarded four clients who have heard from others about HH and who wish to join the program. These are A Minus clients – the "Minus" refers to the absence of program funding. These A Minus clients are indicators of a positive HH experience from past participants. However, these A Minus clients also indicate a need for supports that extends beyond the existing funded clients. The Canadian Mental Health Association (CMHA) recently released a report outlining the results of a survey that asked Albertans about the impact of COVID-19 on their mental health and well-being. The results indicated that COVID-19 caused significant challenges and outlined mental health supports and resources as one of the most pressing future concerns for Albertans (Canadian Mental Health Association, n.d.). Given the need and number of people HH has served already, HH expects to meet the target number of people it intended to serve by the end of the program (n=160). To date, 119 people have received support from HH - 61 and 58 family members from 44 families.

Appointment data shows that clients are participating in most of their appointments to date; there does not appear to be frequent no-shows or withdrawal from HH. In addition, most funded clients have completed, or are in the process of completing, their comprehensive assessments – a pillar and key element of the model. In addition to individuals and family members, HH has engaged with several organizations - social agencies, media, health services, government, foundations, and local business to help bring awareness to mental health and addiction and HH's work. Only one community event has been organized so far; however, HH does intend to facilitate other community information sessions.

Early Outcomes

A key role of the HH operations team is facilitating collection of data for ongoing monitoring and evaluation. The team has done an exceptional job of identifying (or creating) data collection tools and administering those tools to capture baseline data. As a result, this report can report on baseline outcome data.

Knowledge and understanding

The baseline individual and family survey found:

- Most individuals and family members seemed to understand and agree with HH's mental health and addiction principles.
- Over half of HH clients were very clear on HH services and supports.
- Family members seem to have a better understanding of HH services and supports than individuals.

Integrated care
HH has four organizational partners 1) Health Upwardly Mobile 2) Anchor of Hope 3) Care First Medical and 4) Cool Family Solutions. In November 2020, providers from these organizations completed a baseline assessment of their level of integration using the Integrated Practice Assessment Tool (IPAT). At that point, the providers placed themselves at a Level 3 – Basic Collaborative Onsite care. The IPAT will be completed again toward the end of the program to see how integrated the providers are. In addition, interviews will be conducted with service providers to further explore enablers and barriers to integration.

Client outcomes
Individual outcomes are measured using the Canadian Personal Recovery Outcome Measure (C-PROM). We are unable to show the change in pre and post recovery scores at this time, given clients are still participating in their HH journey – this will be reported on in the final report. However, initial analysis shows that clients are mostly completing the C-PROM. So far, individuals have completed an average of three C-PROMs. The average C-PROM score is 13.1, which is in the middle range where generally 40% of the population will score. These middle scores mean people may benefit from care that is targeted at self-esteem and managing stress.

Family outcomes are assessed using a resiliency survey. Comparison of the pre and post scores shows that family members are having improved outcomes in almost all developmental strengths following the 10-week family program. The greatest improvement in scores was related to self-sufficiency and persistence. The feedback from family members on their 10-week program was very positive.

Conclusion and Recommendations

HH has designed a community addiction and mental health model that is now at the interim point of implementation. At this point, service providers are working collaboratively, and clients are participating in its various elements. Early outcome data from family members is positive and shows improvement in most resiliency scores. Individual outcome data is limited at this point given individuals are still participating in HH.

HH's model operates with two notable assumptions that will need to be addressed going forward: 1) that there is an HH operations team and volunteers to support implementation (e.g., training, data management, process improvements, even some elements of the intake process), and; 2) client care is funded (i.e., clients do not pay for their HH care). Given these important elements, HH is beginning to prepare a plan of action for ongoing continuity of HH post program.

There are 13 recommendations outlined in this report (summarized on the following page). Many of the recommendations are targeted at process improvements the HH operations team can make in the next stage of the program. The next stage of the evaluation will focus on measuring and describing how effective the model is in supporting people with mental health and addiction challenges.

RECOMMENDATIONS	
1	Determine the cost of HH and estimate the costs for ongoing supports post pilot. Outline in these costs the ongoing service provider and operational support that is needed, as well as the ongoing client costs.
2	Explore with the HH service providers what it would take to move the team to a Level 6 on the IPAT. Work with the team to implement their suggested approaches and process improvements.
3	Conduct the IPAT again toward the end of the program to understand if the team has become further integrated. Interview service providers to understand the enablers and barriers to integration.
4	Continue/complete training programs underway or planned for professional and community team members. Consider incorporating a pre/post questionnaire to understand how training has supported knowledge and understanding of HH and its principles.
5	Continue with operations training for service providers and community supports in the interests of continuous improvement as well to identify gaps and recommendations for recording in final report.
6	Continue to work with service providers to encourage consistent documentation in AirTable and Nula.
7	Continue client care (professional and community supports) and evaluation plans already underway with *existing clients*. Complete those care plans already established and underway and have available full data suite from inception to completion.
8	Continue client care (professional and community supports) and evaluation plans for *future clients* as budget constraints allow. Provide care plans for client and have available full data suite from client experience.
9	Develop a list of attendees and a communication and recruitment strategy for the community information sessions. Use the event to capture what information and connections people/organizations need and use that to build out the community strategy portion of the program.
10	Consider alternate communication mediums to enhance understanding of HH services and supports, particularly aspects related to community supports.
11	Review with service providers the process for administering and entering C-PROM data.
12	Consider how the existing services and supports align with the C-PROM data that is gathered.
13	Continue to administer the adult resiliency questionnaire. Review to what extent the program does or does not align with the developmental strengths.

Introduction

Jesse Braden Titus "Braden" died tragically from suicide after not receiving the mental health care he needed in the weeks leading up to his death. In 2016, Braden's family established the Thumbs Up Foundation (TUF). In the words of his mom and foundation co-founder, TUF was established to "try to make some sense out of this senselessness" and to advocate for positive change for mental health.

One of the feature initiatives of TUF is the Harmonized Health Program (HH). HH is intended to be a new, different and more effective way of supporting people with mental health and addiction challenges. HH aims to provide seamless, integrated care that puts people (as opposed to the system) first. The aim is not to replace, but rather to complement existing community services, connecting adults (16 and older) with mental health and addiction challenges to available local resources, from prevention through the continuum of care, following current evidence-based approaches. Its "people first" approach is intended to result in improved individual and health system outcomes.

"This is not just about providing good quality of care to people in an integrated way - that's how [Harmonized Health is] doing it. But this is about systemic change." – HH operations team member

An evaluation will assess and measure the outcomes of HH's approach. This interim evaluation report was produced as part of that evaluation. This report focuses on a) defining HH's model of care, and; b) understanding to what extent it has been adopted by individuals, family members, service providers and community agencies. Early outcomes are also reported; however, these will be reported on fully in the final report (August 2021).

Background

Why is change needed?

Kim's personal experience emphasizes why change is needed to the mental health system; unfortunately, her son's experience represents many Albertans. The Gap Analysis of Public Mental Health and Addictions Programs (Wild, Wolfe, Wang, and Ohinmaa, 2014) reports one in five Albertans suffer with an addiction or mental health concerns. This is equivalent to 311,355 people (about 1 in 10 Alberta adults), or more adults than the populations of Red Deer, Lethbridge, Wood Buffalo and Medicine Hat combined. However, these numbers are only part of the story. The impact of mental health problems extends beyond individuals to their family members. In 2012, about 38% of people in Canada had a family member with a mental health concern and 19% of these people said it affected their own mental health (Mental Health Commission of Canada, 2017).

The Alberta Government Valuing Mental Health report (Alberta Government, 2015) found that for adults who met criteria for a past-year addiction or mental health problem, almost half reported unmet needs for one or more services – either they needed services but didn't receive any service or didn't receive enough service (Alberta Government, 2015). Unmet needs for counselling are most reported. Some counselling is available through AHS; however, many qualified counsellors operate privately, outside the system of publicly-funded care. The second most common reason underlying perceived unmet need for care is inability to afford services (Wild, Wolfe, Wang, and Ohinmaa, 2014).

The Alberta Government Valuing Mental Health report (Alberta Government, 2015) describes the inequality that exists between mental health care and care that targets physical health. The review explains that addiction and mental health issues are not treated with the same urgency as those related to physical health. Despite the growing demand for addiction and mental health services, only six per cent of health care spending goes to these services, when the recommended amount is nine to more than 13 per cent (as cited in Alberta Government, 2015). This disproportionate allocation of funding results in inequality in care. Wild et al. (2014) found that most surveyed programs and services (49% and 67% of AHS direct and contracted services, respectively) indicated that more people sought services than they had resources to accommodate. These delays or inadequate treatment impact people's health and further contribute to health system burdens and increasing costs (Alberta Government, 2015).

The long-term impacts of not meeting the needs of nearly half the affected population have many social and financial ramifications. The Mental Health Commission of Canada [MHCC] (2017) describe some of the impacts from failing to make mental health a priority. Some of these effects include, more people living with disability, shorter life expectancies, increased struggles with housing and homelessness, and increased incarcerations.

What change is needed?

The Alberta Government Valuing Mental Health report (Alberta Government, 2015) was compiled after "six months of study, analysis, deliberation and consultation with thousands of Albertans" (p.1). The report outlines the issues and barriers with the current system (described on the previous page), but also illustrates what the vision is for a reformed addiction and mental health system. The intended outcomes from the mental health reform are:

- Albertans have ***increased awareness of how to access quality services and supports*** when they need them.
- Service providers have ***increased communication, understanding and accountability*** for roles and responsibilities in the integrated service delivery system.
- Albertans have increased awareness and confidence that addiction and mental illness is ***preventable, manageable and recoverable, and share responsibility*** for wellness, health and recovery.
- Government departments, non-government organizations and service providers have ***increased accountability for the delivery of cost-effective, integrated services that improve the mental health of Albertans.***

Alberta's Mental Health Review Committee also made a number of recommendations to help achieve these outcomes. The recommendations are based in three overarching principles:

- Individuals are seen in a ***holistic way***, where prevention is a priority and early intervention leads to better treatment and recovery.
- Leadership provides transparent, accountable and ***adequately resourced services and supports.***
- The constitutionally protected rights of First Nations, Métis, and Inuit people and communities are ***honoured and respected, and they are supported in addressing the addiction and mental health needs*** of their communities.

The beginnings of Harmonized Health

The Alberta Government's Valuing Mental Health report was released in 2015 – the same year Kim Titus lost her son. Shortly after the loss of her son, Kim and her family started TUF and began engaging with others dealing with mental health and addiction concerns, but also organizations trying to address those concerns.

One of those organizations was a local organization called **Cool Family Solutions** - an organization focused on supporting families with loved ones struggling with mental health and addiction (Cool Family Solutions, 2018). TUF had successfully partnered with Cool Family Solutions to run a project. Cool Family Solutions then connected TUF to another local organization called Anchor of Hope.

Anchor of Hope (AOH) is an Airdrie organization that offers counselling services, recovery in addiction, and individual and group therapy (Anchor of Hope, 2021). TUF recognized early on that it was important to have counselling services available to refer people to. However, the counseling needed to be a counsellor that offered a "likeminded approach." AOH met that criteria.

Kim was also fortuitously introduced through a mutual connection to the chairman of the **Foundation for Addiction and Mental Health** (FAMH). Kim could see there was alignment between FAMH and TUF after meeting with FAMH 's chairman. Both organizations recognized the gaps to addressing addiction and mental health in the existing system and the need for systemic change. FAMH outlined what Kim calls as a "future approach to mental health." In other words, an approach that recognizes the physiology behind addiction and the importance of a comprehensive assessment as a basis for treatment. This approach is outlined in a FAMH pamphlet called "Identifying and Treating Addiction," which has since become one of the approved documents adopted by HH.

Health Upwardly Mobile (HUM) was another organization that TUF engaged with early on. HUM is an integrated interdisciplinary team of healthcare professionals including medical doctors, registered psychologists, social workers and nurses who provide holistic assessment and treatment for addiction, mental health and chronic pain (Health Upwardly Mobile, 2020). HUM's treatment plan is based on a comprehensive assessment – a process developed by its physician to explore a person's full history, symptoms and acuity of issues so an accurate diagnosis(es) and individualized treatment plan could be made (Health Upwardly Mobile).

The HH program began to formalize from the discussions that were occurring between TUF and these four other organizations. Together, these organizations began to explore how they could create a community model that integrated each of their expertise.

Evaluation Overview

Evaluation History

An external evaluator has worked with HH since it started in August 2020. The external evaluator was hired to refine and clearly define the program vision and mission, as well as develop a program logic model (Appendix A) to help inform program design, articulate deliverables and related desired outcomes. This work (defined as Evaluation – Phase 1) generated a shared understanding amongst stakeholders and set the stage for this phase of the evaluation (Evaluation – Phase 2).

Three Hive Consulting ("Three Hive") was contracted in December 2020 to carry out Phase 2 of the evaluation. Three Hive worked with the HH operations team to clarify the purpose and scope for the Phase 2 evaluation.

Evaluation Purpose

This evaluation (Evaluation – Phase 2) is being conducted to **a) better understand and define HH's model, and; b) measure how effective the model is in supporting people with mental health and addiction challenges.** HH also recognizes that evaluation can but used to provide ongoing support and learning to the program. The information from the evaluation will be used to inform operational processes; however it will also be used to inform and advocate for reformed addiction and mental health care.

Evaluation Question 1: What is the Harmonized Health model of care? ★

Evaluation Question 2: To what extent has Harmonized Health's model of care been implemented?

Evaluation Question 3: To what extent has Harmonized Health's model been adopted? ★

Evaluation Question 4: How effective is Harmonized Health's model of care?

★ Indicates the focus for this report

Interim Evaluation

The purpose of this interim evaluation report is to gather, analyze and summarize HH documentation and baseline data. This interim report will be used to meet funder requirements, but also to identify where improvements can be made to the program. This report focuses on answering evaluation question #1 and #3. These questions and evaluation questions #2 and #4 will be explored in greater detail in the final evaluation report.

Interim Data Sources

This report contains data from the following sources. For a more detailed description of the methods used refer to the relevant sections in the report and Appendix B.

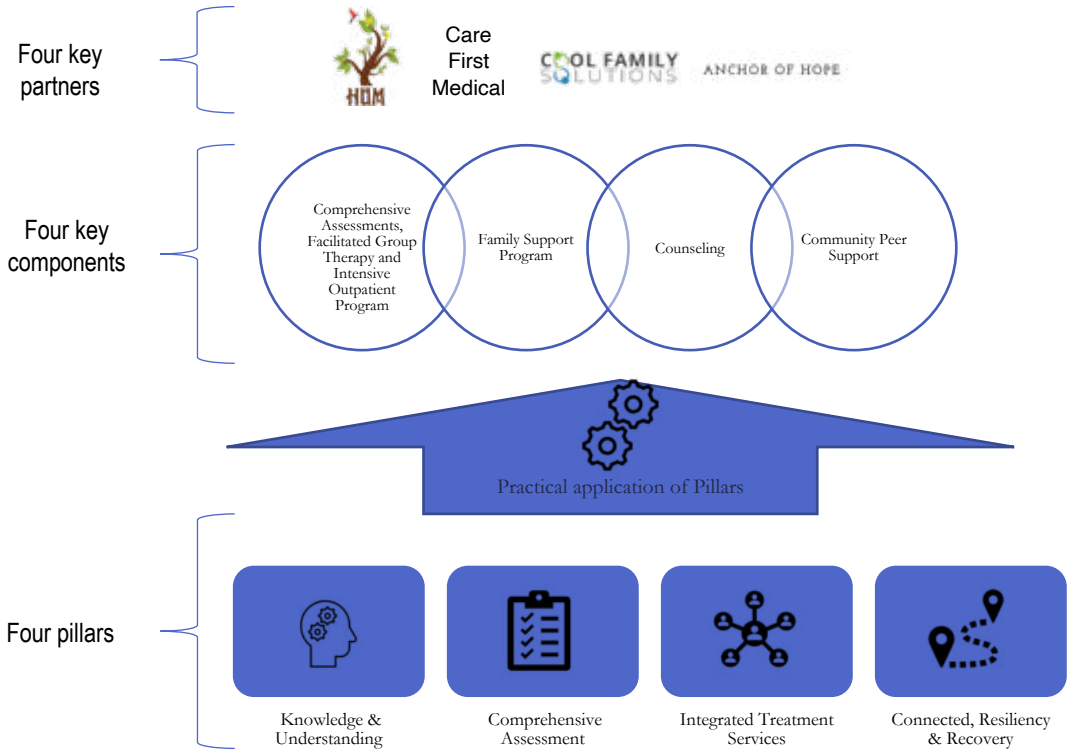
	Documentation	*HH database*	*Interviews*	*Client Experience survey*	*Family Experience survey*	*Family Resiliency and Assessment Tool*	*Symposium Survey*	*IPAT*	*C-PROM*
Evaluation Question #1	√	√	√						
Evaluation Question #2	√	√	√				√		
Evaluation Question #3		√	√	√				√	
Evaluation Question #4	√		√	√	√	√	√	√	√

Harmonized Health Overview

Harmonized Health Model of Care

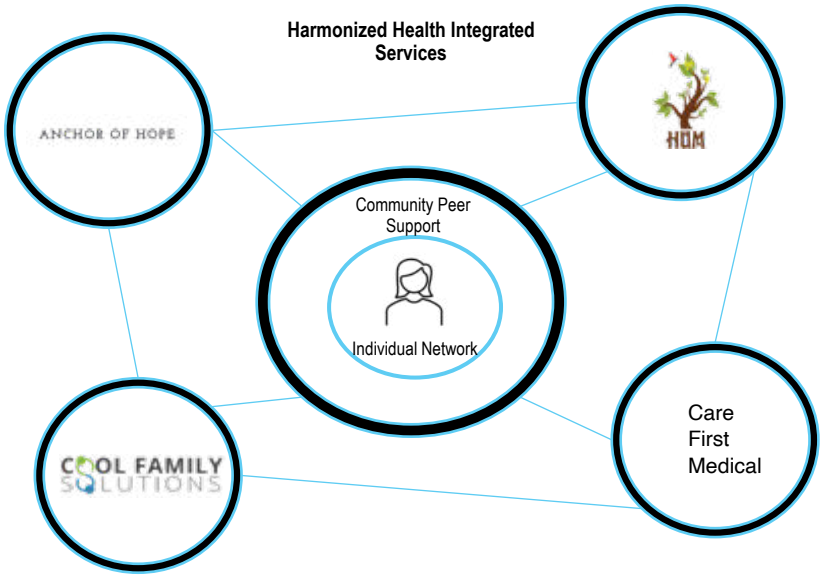
HH designed a community addiction and mental health model designed around **four key pillars:**
1) Knowledge and Understanding
2) Comprehensive Assessment
3) Integrated Treatment Services
4) Connected Resiliency and Recovery

Those pillars are operationalized by four partner organizations delivering **four key components:**
1) Comprehensive Assessments, Facilitated Group Therapy and Intensive Outpatient Program (IOP)
2) Family Support Program
3) Individual counseling
4) Community Peer Support



Integrated Treatment Services

HH service providers and community peer support(s) are focused on providing clients with an integrated, client centered approach to care. They work together so individuals are accurately diagnosed and are receiving the proper levels of professional support, peer group support and their own family involvement, each at the proper time, and respecting where each individual is at.



Family Support Program

Family support is often an ignored piece when addressing mental health and addiction. It is important to include families in the recovery journey since the impact of mental health concerns extends beyond individuals and to their families (Mental Health Commission of Canada, 2017). In addition, family is the most central part of an individual's support network. By incorporating family into an individual's recovery, HH is providing a more comprehensive, prevention-based approach that will help mitigate the perpetuation of mental health and addiction issues in communities.

"The least healthy member of the family is driving the family bus. And when they do well the whole family does well. And when they don't do well, they take the family down the rabbit hole with them."
– HH operations team member

The family support program is delivered through Cool Family Solutions. The program is a ten-week program that focuses on equipping family members with strategies on how to engage in honest conversations about difficult situations regardless of their loved one's state of readiness for change. These conversation include:

- How to listen so others open-up to what is happening in their life.
- How to respond and not react.
- How to engage in healthy honest dialogues.
- How to set good wholesome boundaries.
- How to validate what is working to increase more positive behavior.

Community Peer Support

HH offers community peer support in addition to its professional services offered through Care First Medical (CFM), HUM and Cool Family Solutions. Its community and peer support element is an intrinsic, unique component of HH. The peer element of HH is available through three main types of community peer support:

1) *Comprehensive Assessment Navigator* - Someone who has had a comprehensive assessment, is very familiar with the clinical process and the overall fit of the comprehensive assessment process within the HH framework. This person can explain/answer questions on the assessment process to a new client of HH.
2) *Peer Navigator* – A community member who is familiar with HH, is in recovery within the program and can walk with a new client through the early stages of their recovery journey from a lived experience perspective.
3) *Peer Group Facilitator* – A community member with sufficient experience or training in order to organise and facilitate a small group (or groups) of HH clients for regular recovery meetings.

Knowledge and Understanding

Integrating professional and peer support under the HH umbrella means care can be delivered in a consistent, cohesive approach that supports knowledge and understanding. The Valuing Mental Health document (Alberta Government, 2015) reports there is a general lack of awareness and understanding of addiction and mental health. About one-quarter (24.6%) of surveyed Albertan adults with a past-year addiction or mental health problem reported unmet needs for information about addiction and mental health problems, treatments, or available services (Wild, Wolfe, Wang, and Ohinmaa, 2014). Service providers working in HH partner organizations receive training to present facts about addiction and mental health using common language and terminology. In addition, HH believes that knowledge and understanding is enhanced when people are provided with peers who are familiar with HH and the recovery journey. Therefore, an intrinsic component of HH is its community and peer support element.

Comprehensive Assessment

Shared knowledge and understanding begins with a proper diagnosis. Comprehensive Assessment is a key pillar and component of the HH model because it is a means for determining a proper diagnosis and an appropriate treatment and recovery plan. It is a 3-hour assessment that addresses the biopsychosocial and spiritual aspects of mental health and addiction to determine what is really the chronic root of the individuals' condition.

Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environments, and an individual's life experiences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases (American Society of Addiction Medicine, 2021). Therefore, the diagnosis by a professional, together with a treatment and recovery plan co-created by the patient and physician, are essential. Without a proper diagnosis and treatment plan individuals are often left not receiving the appropriate treatment or any treatment at all.

Comprehensive Assessment – "A deep dive"

- Mental health symptoms
- Physical health symptoms
- Adverse life consequences
- A desire for change

- Family history and current relationships
- Social situation (past and present)
- Values
- Psychological
- Biological factors

"

A comprehensive assessment, which I colloquially call a deep dive because it's what's beneath the water surface. ***If you look at mental health or one's health as an iceberg, what we see is above the water line and what others see is above the waterline,*** *and what others see is what others respond to.*

But really, all the actions going on are under the water line and we try and bury that. We stuff it away. Quite often we are incapable of actually identifying it. We don't know it's there. It can be even genetic; in fact, it usually is genetic. So how the hell are we supposed to know about these things? We're not. The only way we can get to the bottom of it is through a comprehensive assessment.

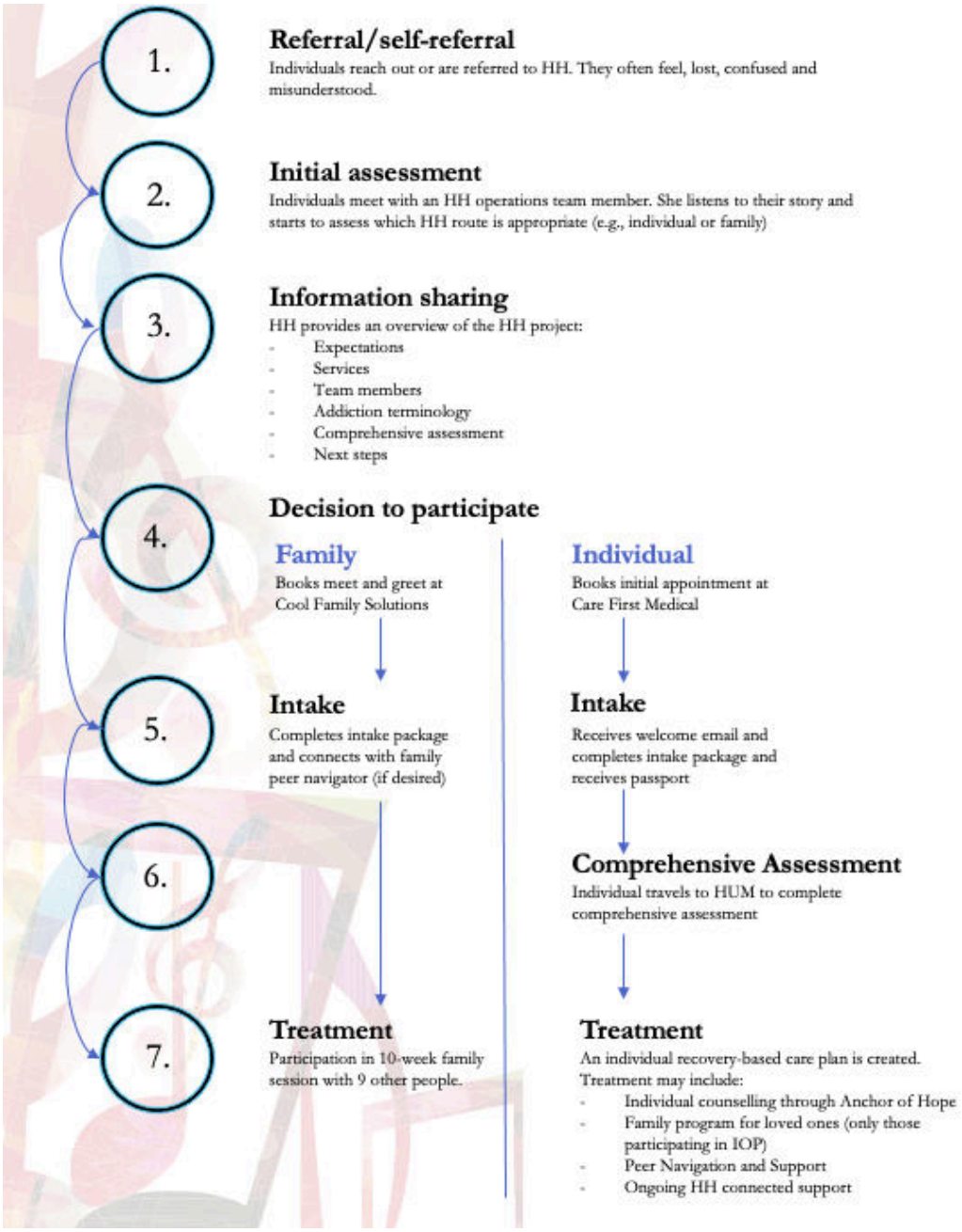
– HH operations team member

"

Connected Resiliency and Recovery

Individuals need to be supported so that they can be met where they are at with their own mental health journey and to begin to develop skills to build the resiliency required to face adverse life events. Following the comprehensive assessment, each client is provided with a recovery-based care plan and appropriate tools to be employed as necessary. Their progress is assessed with assessment, treatment and recovery data shared among participating service providers. The following figure outlines the HH client journey.

Harmonized Health Resiliency and Recovery Journey



Harmonized Health Outcomes

The following table outlines the *intended* outcomes HH is trying to achieve. Each row represents the intended beneficiary from HH's work. The top of the table represents beneficiaries where HH will have the most influence for change; the bottom of the table are beneficiaries where HH will have less influence for change. It is important to note that one of the main assumptions that underpins HH's ability to achieve these outcomes is that funding is available for client care (e.g., comprehensive assessments, counseling, etc.).

Level of influence

High

Beneficiary	Intended Outcomes
HH Service Providers	**Enhanced engagement** by working together in an integrated, community-based model, which will support the fostering of a common understanding of current brain health, client centred approaches and language related to mental health and addiction. **Improved efficiencies in care delivery** by providing service providers with ready access to, and application of, standardized care practices (e.g., comprehensive assessment, shared HH client recovery/family care plan and passport, shared HH database). **Enhanced satisfaction** with their ability to collaborate amongst each other and with their clients to provide high quality, client centred care.
HH Client (individuals and family)	**Enhanced knowledge and understanding** of current brain health knowledge, care principles and language regarding mental health and addiction. Enhanced knowledge and understanding will mean more clients seeking care. **Improved access** to timely mental health and addiction crisis support, and early intervention (both virtual and in-person), as coordinated through client centred and integrated approaches to service delivery. **Enhanced engagement in care,** where clients experience their care team working collaboratively with them, and amongst themselves, to develop a shared care plan. **Improved satisfaction of care** from its integrated care coordination. **Improved health outcomes** • Attainment of personal recovery goals and mental health and addiction ownership. • An increase in personal resiliency as a result of learning, developing and applying recovery and resiliency tools.
Community	**Improved access** to a local, community-based prevention and early intervention for individuals/families in need. This includes clinical treatment and ongoing community-based support (clinical and non-clinical) for HH clients as well as opportunities for all community members to enhance their awareness and knowledge of mental health and addiction via community events. **Increased responsiveness, consistency, and capacity** through an Airdrie Recovery Community model of care for mental health and addiction. **Improved social outcomes** for individuals and families. **Evidence informed system of integrated community-based care model** for Airdrie (and beyond in the long-term).
Health System	• The provision of effective and safe care for every individual/family in need. • Earlier detection of mental health and addiction challenges. • Reduced acute care usage and acute care costs. • Evidence informed system of integrated community-based care model. • A transferrable model, in whole or in part for adoption in other communities. • The initiation of a shift from an acute care focused model to a prevention-based community model.
Society	• Increased employment • Decreased incarcerations • Increased life expectancy

Low

Harmonized Health Population

Who does Harmonized Health care for?

HH provides care to people who meet the following criteria:

- Youth (16 and older) & adults.
- Medically stable (i.e., currently not experiencing conditions that limit capacity to follow-through with HH commitments).
- Mental health and/or addiction challenges (self or concern for others).
- Expressed readiness for change (prepared for action) and commitment to participating in HH (first engagement or re-engagement with HH).

(Originally people were to reside or be employed in Airdrie and area (i.e., Irricana, Balzac, Beiseker, Crossfield). However, HH has since expanded its geographic criteria beyond Airdrie & Area. Virtual service has allowed for this to happen, particularly for the family program and individual counseling.

TUF began providing services in November 2016; however, services were formalized into the HH program in August 2020. HH has since categorized the people it has provided services to into three categorizations. These categorizations help to differentiate the level and type of service people have received over the years.

Category Definitions

CLIENT A: Individuals experiencing the full range of seamless, integrated clinical and community services since August 14th, 2020 onwards. This includes comprehensive assessments, counselling services, community navigator, peer group sessions, including psychotherapy, and family group services (where applicable). Note – some of these people may have previously had some services financed by TUF prior to August 14th, 2020.

CLIENT A Minus: The "minus" refers to the absence of program funding. These are people who have heard from others about HH and who wish to join the program. Due to pilot funding constraints, these people will either be funding themselves for the cost of provision of professional services or a hybrid of funding through TUF. These people will be able to participate in all HH community led services as they would as a Category A client. The client care process will be the same as for Category A clients subject to funding.

CLIENT B: Individuals or family members who have prior to August 14th, 2020 availed themselves of one or more of the services developed at that time (particularly comprehensive assessment) by HH.

CLIENT C: Represents the historical approach of an individual to TUF expressing an interest in further information on HH and/or mental health in general. Or could be persons who did have a TUF subsidized/funded or self funded service but who elected not to continue with HH.

What is the number of people HH has served?

119

is the number of people served by Harmonized Health

There have been **61 individuals** served through Harmonized Health

Category	Total people
Category A	12
Category A Minus	4
Category B	19
Category C	26
TOTAL	**61**

There have been **58 family members** served through Harmonized Health (from 44 families). There are currently 8 people on the waiting list for the next family session.

Session Start Date	Men	Women	Families	Total unique people
February 10, 2021 (Currently underway)	3	7	8	10
November 12, 2020	4	5	6	9
October 30, 2020	3	7	9	10
May 28, 2020	5	7	8	12
Other historical sessions	4	13	13	17
TOTAL	**19**	**39**	**44**	**58**

Adoption of the Model

Service Provider Engagement

*To what extent are **service providers** adopting Harmonized Health?*

Knowledge and understanding is one of the four pillars of HH. Given this, training is an important aspect of HH's model. The HH service providers, operations team and peer community supports have received numerous hours of training and guidance. The number of people trained, and the type of training is captured below. The type of training has been categorized according to three categories: 1) Program Training, 2) Clinical Training, and 3) Community Support Training.

1. Program Training

Program training is focused on refining and improving the program when a client engages with the various community and professional services available to them under the HH umbrella. Part of that training is training related to HH language and principles. One of HH's physicians presented a seminar to the HH team on the "Language of Addiction and Mental Health" as part of this of the onboarding training.

Program training also includes capturing and recording client data in a shared electronic database (i.e., AirTable) for ongoing process improvements and evaluation purposes. HH has an Operations Coordinator who is responsible for designing and managing the shared client database. She has completed AirTable Product Training Modules and is responsible for reviewing and following up with the service providers to maintain data accuracy and completeness.

2. Clinical Training

In addition to program training, it is also important that service providers receive specialized mental health and addiction training. HH has facilitated conversations between Care First Medical and HUM and they have agreed that the best way for service providers to received specialized mental health and addiction training is through mentorship training facilitated by HUM.

Service providers in training would usually attend the HUM Intensive Outpatient Program (IOP) and certain HUM client appointments. In addition, service providers would work with HUM on learning the practice of group psychotherapy facilitation by attending the HH sessions and debriefing with the HUM specialists afterwards.

3. Community Supports Training

The roles and responsibilities of the peer navigator have been outlined. Training documentation has been developed in conjunction with the HH medical advisor. Five community navigators have had two peer navigation training sessions related to processes and boundaries. Further training is planned to further consolidate what has been done so far as well as for any new peer navigators. In addition, development of an accredited mentorship program for peer support personnel is currently under consideration.

There have been 20 people trained through Harmonized Health. Harmonized Health plans to train 16 more people by the end of the program.

	# trained	# planned for future training
HH operations team	5	2
Service provider team	12	9
Peer/community supports	3	5
TOTAL	**20**	**16**

The table on the following page provides a breakdown of who has received which type of training (indicated with a '✓'). It also outlines planned HH training (indicated with a 'P'). Any cells that are crossed out mean the training is not applicable for the HH role.

✓ = Completed Training P = Planned Training	Program Training					Clinical Training				Community Supports Training	
HH Operations Team	*Background/ Onboarding*	*Evaluation Methodology*	*Processes*	*Database/ AirTable*	*Database/Nula*	*Counseling*	*IOP*	*Mental Health First Aid*	*Psychotherapy Group*	*Basic Peer Navigator*	*Peer Group Facilitation*
Lead 1	✓	✓	✓								
Lead 2***	✓	✓	✓	✓							
Operations Coordinator	✓	✓	✓	✓	✓						
Peer Coordinator**	✓P		✓P								
Project Assistant	✓P	✓	✓P	P							
Service Provider Team											
Care First Medical Physician 1	✓P		P			P	✓P		P		
Care First Medical Physician 2	P		P			P	P		P		
Care First Medical Nurse 1	P		P								
Care First Medical Admin	✓P		✓P	✓	✓						
Care First Medical/Health Upwardly Mobile Physician	✓		P								
Health Upwardly Mobile Physician	✓										
Health Upwardly Mobile Nurse 1	✓		✓P	✓	✓						
Health Upwardly Mobile Admin	✓P		✓P	✓	✓						
Health Upwardly Mobile Counsellor	✓P		P	P	P						
Anchor of Hope Counsellor	✓		✓P	✓	✓		✓				
Cool Family Solutions Counsellor	✓		✓	✓				✓			
Cool Family Solutions Admin	✓			✓							
Community Supports Team											
Peer Navigators*	✓									✓	P
Peer Navigators (Future)	P									P	

* Peer Navigators will usually have had experience such as having completed a comprehensive assessment, undergone/undergoing counselling , or other HH services.

** Has experience of counselling, full IOP, comprehensive assessment and family group within HH; hence is acquainted with range of services.

*** Has experience of comprehensive assessment, individual counselling, group counselling, part IOP (individual), part IOP (family),12 step (including chair), peer navigation, sponsorship and mentoring.

Individual Engagement

To what extent are individuals adopting Harmonized Health?

The following table show how many (and the proportion) of individuals who have completed appointments, according to appointment type. **It is important to note that many of the A and A Minus clients are currently still participating in the program so these numbers and proportions represent who has completed appointments until now.**

The majority of individuals have completed (or are currently completing) the various HH appointments. Around three quarters of historical clients (B clients) have completed AOH and HUM appointments.

Category of Client	Total Clients	AOH	CFM	HUM	IOP
A	12	8 (67%)	10 (83%)	8 (67%)*	3 (100%)***
A Minus	4	1 (25%)	3 (75%)	1 (25%)**	
B	19	15 (79%)	N/A	14 (74%)	
TOTAL (A & A Minus)	16	9 (56%)	13 (81%)	9 (56%)	
TOTAL (All)	35	24 (69%)	N/A	23 (66%)	

*The other four individuals are in progress

**One person is in progress

*** Only three people were funded for IOP

# of Comprehensive Assessments completed

	Client A	Client A Minus	Client B
Completed	8 (67%)	1 (25%)	15 (79%)
In Progress	4 (33%)	1 (25%)	N/A
Incomplete	0	2 (50%)	4 (21%)

Community Engagement

Which community organizations has Harmonized Health engaged with?

HH knows that stigma remains a major barrier with mental health and addiction care. More than 60 percent of people with addiction and mental health issues will not seek the help the need - stigma being one of the main reasons for not seeking care (Alberta Government, 2015). Given this, HH has included community engagement as part of its model to try and increase awareness and knowledge of mental health and addiction issues, standards, and care delivery models like HH. To date, HH has engaged with the following people and organizations.

STAKEHOLDER GROUP	STAKEHOLDERS
SOCIAL AGENCIES	• 100 Men Who Give a Damn • Airdrie Food Bank • Airdrie Victim Services • Canadian Mental Health Association - Alberta • Talent C • Guitars for Vets • Meals on Wheels • Alberta Mentoring Partnership (Peer Mediation & Support Training)
MEDIA	• Air 106 Radio • Airdrie City View • Airdrie Echo • Airdrie Life Magazine
HEALTH SERVICES	• Alberta Health Services • Highland Primary Care Network • Various physicians
GOVERNMENT	• Airdrie City Council • Airdrie RCMP • Airdrie Resource Council • Assoc Minister Jason Luan • City of Airdrie Economic Development Board • City of Airdrie Social Planning • Dr. David Swann • Mayor Peter Brown • MLA Angela Pitt • MLA Peter Guthrie • MP Blake Richard
FOUNDATIONS	• Airdrie Community Foundation • Airdrie Rotary • Calgary Foundation • Soul Sisters Foundation
BUSINESS	• Catherine Brownlee + Group • Golder & Associates • Life Support 247 • Marr & Company

Early Outcomes

Service Provider Outcomes

*To what extent are **service providers** providing integrated care?*

One of the key outcomes and pillars of HH's work is integrated treatment and services. There are many definitions used to describe 'integration.' Given this, *A Standard Framework for Levels of Integrated Healthcare* was developed with six levels of collaboration/integration (Waxmonsky, 2014).

Coordinated Key Element: Communication		Co-Located Key Element: Physical Proximity		Integrated Key Element: Practice Change	
LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5	LEVEL 6
Minimal Collaboration	Basic Collaboration at a Distance	Basic Collaboration Onsite	Close Collaboration Onsite with Some Systems Integration	Close Collaboration Approaching an Integrated Practice	Full Collaboration in a Transformed/Merged Integrated Practice

The Integrated Practice Assessment Tool (IPAT) (Waxmonsky, 2014) was developed to place practices on the level of collaboration/integration defined in the above framework. The IPAT uses a decision tree model that uses a series of yes/no questions that cascade to a specific Level of Integrated Healthcare determination.

The IPAT was completed in November 2020 with the HH operations team and the HH service providers. The HH team identified they were at a Level 3 (Basic Collaboration Onsite).

Service providers are providing Basic Collaborative Onsite care.
The HH Operations Team's 'pre' score was a Level 3.

IPAT Question		IPAT Answers
1	Are behavioral health & medical providers in (physically or virtually) one facility?	Yes
2	Are medical and behavioral health providers equally involved in the approach to individual patient care and practice design?	Yes
3	Are behavioral health and medical providers involved in care in a standard way across all providers and patients?	No
7	Do provider relationships go beyond increasing successful referrals with an intent to achieve shared patient care?	No **Level 3**

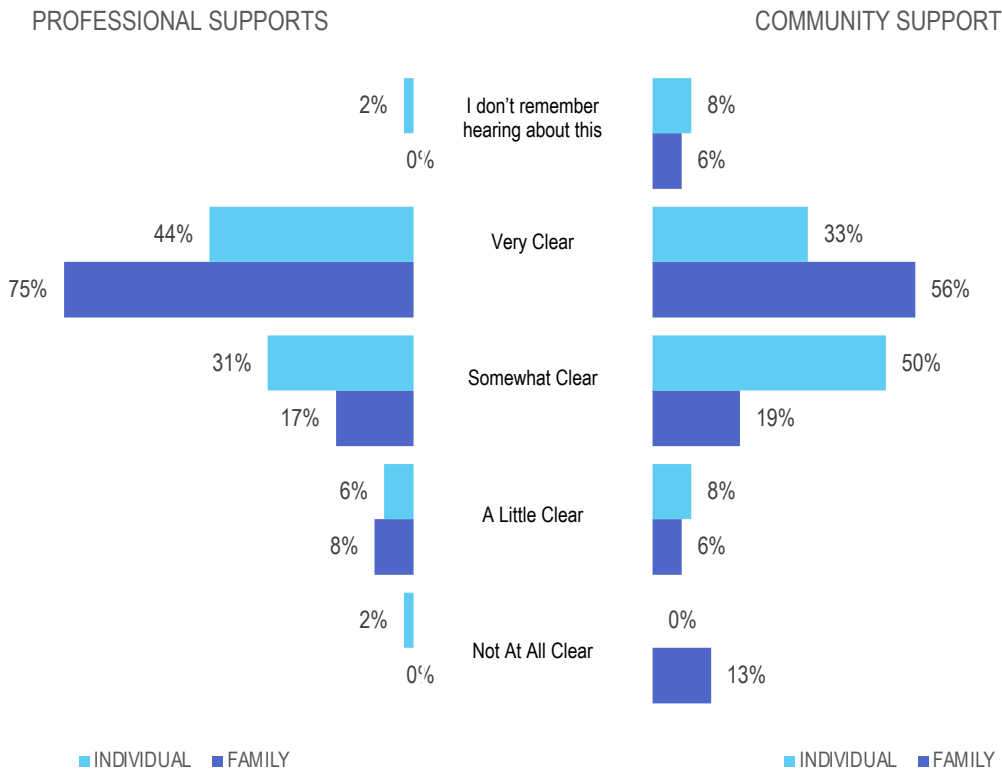
Client Outcomes

*To what extent is there an **enhanced understanding** of the Harmonized Health model?*

The following data is from the individual and family baseline surveys that are administered upon intake into HH. For more information on the survey refer to Appendix B. The survey results are from six individuals and eight family members.

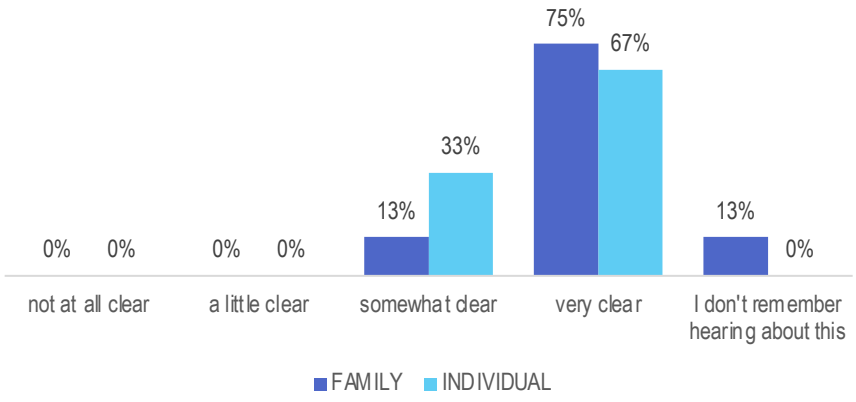
The following graphs show how individuals and family members responded when asked how clearly HH services were explained to them. Specific services (i.e., elements of the model) were aggregated into "professional supports" and "community supports." Refer to Appendix B for further details.

Over half of clients were very clear on Harmonized Health services and supports. More clients were clear on the professional supports than community supports.

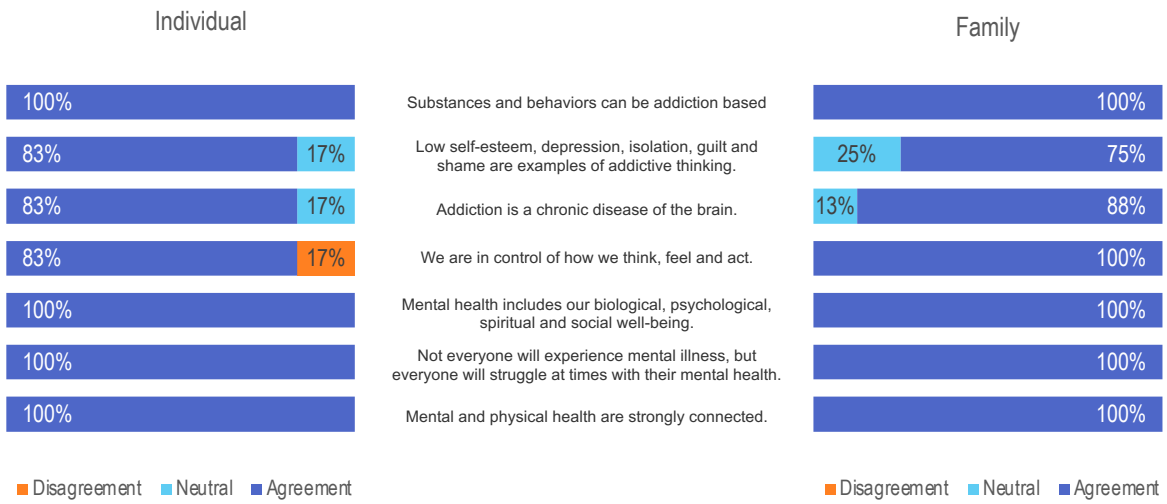


Individuals and family members were also asked on the baseline survey how clearly the addiction and mental health principles were explained to them. They were also asked to rate their level of agreement with HH's addiction and mental health principles.

Most clients were very clear on **the overview of addiction and mental health principles** that guide practice at Harmonized Health.



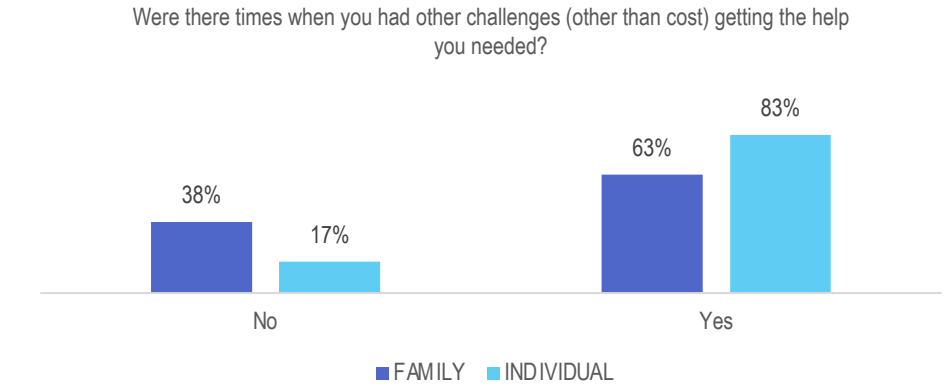
Nearly all clients agreed with the knowledge statements – indicating understanding of Harmonized Health's mental health and addiction principles.



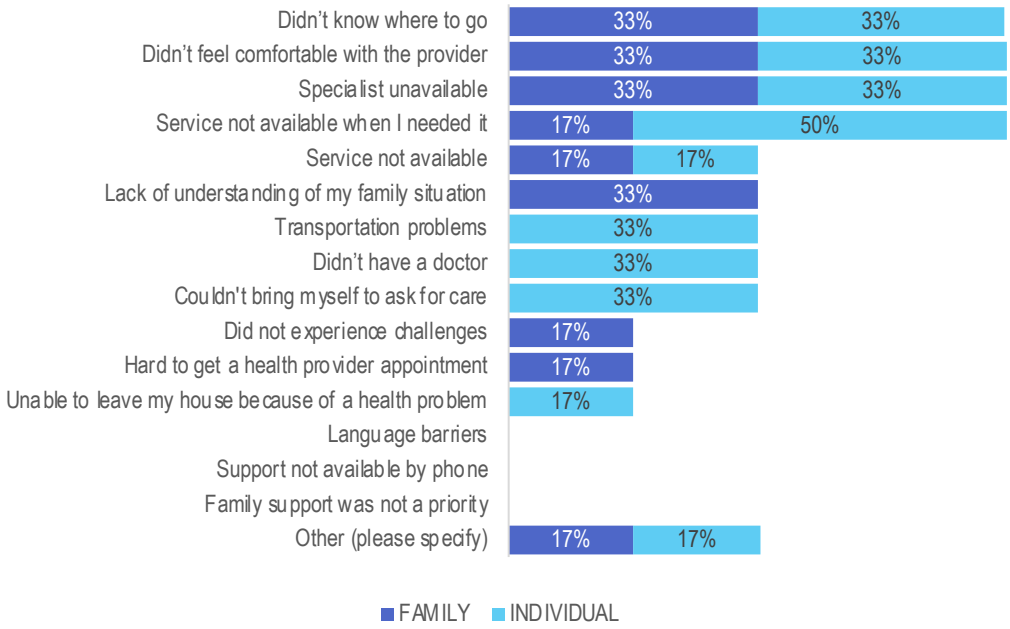
How satisfied are clients with their care experience?

The baseline individual and family survey data asks clients to indicate their experience **PRIOR to hearing about HH.** The following data shows the proportion of individuals and family members who expressed challenges getting the help they need prior to HH. The types of challenges experienced are also outlined below.

Most clients indicated challenges getting they help they needed. The biggest challenges were not knowing where to go or how to access the appropriate care at the right time.

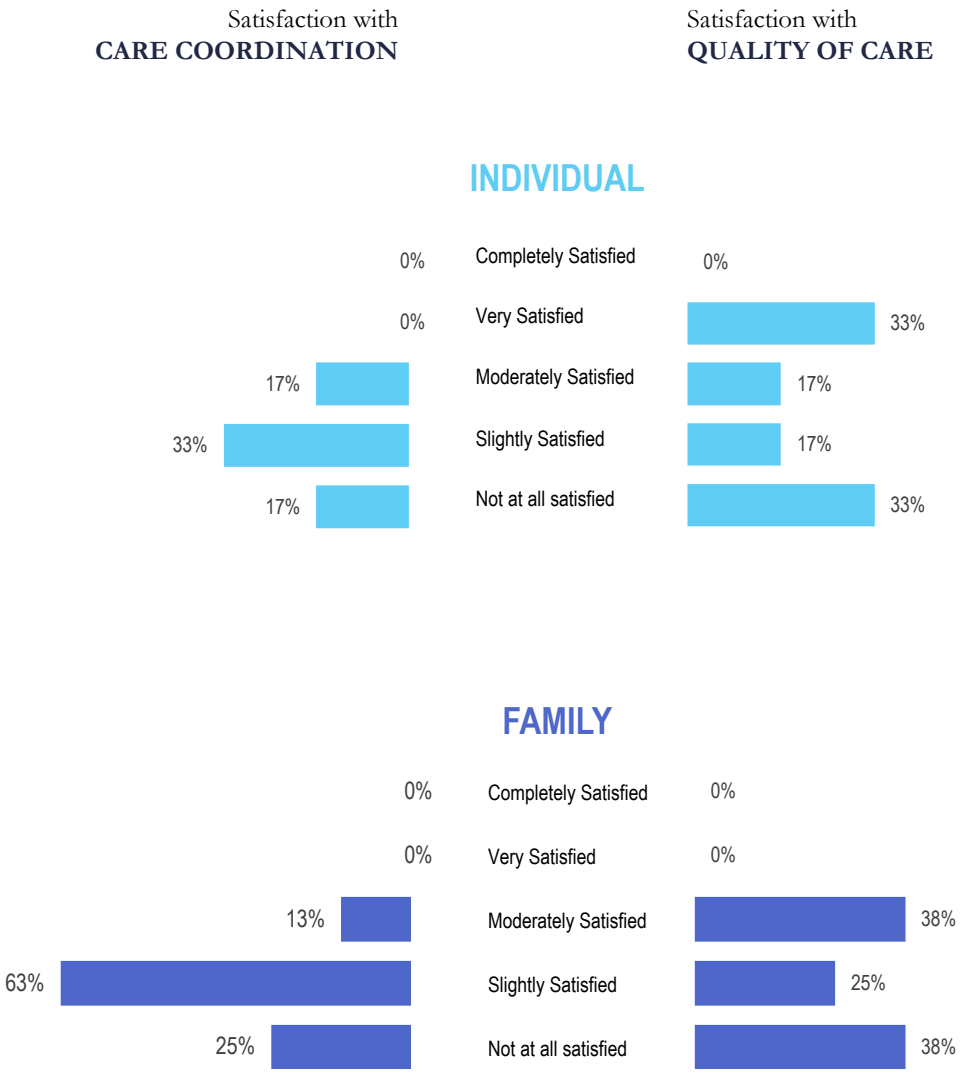


Types of challenges



The baseline individual and family survey data asks clients to indicate their experience **PRIOR to hearing about HH**. The following data shows the proportion of individuals and family members who expressed satisfaction with the care coordination and quality of care they received prior to HH.

No clients indicated being completely satisfied with their care coordination or quality of care PRIOR to Harmonized Health. At least half were slightly or not at all satisfied.

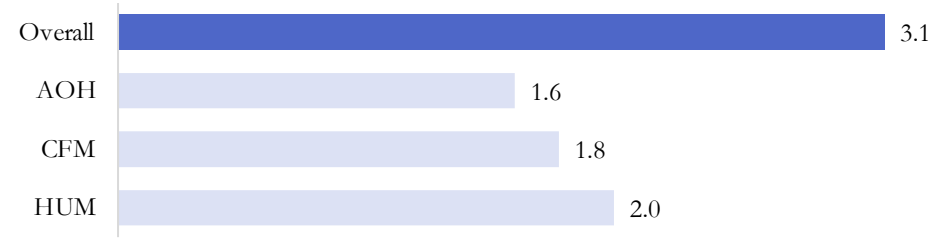


*To what extent do **individuals** have improved outcomes?*

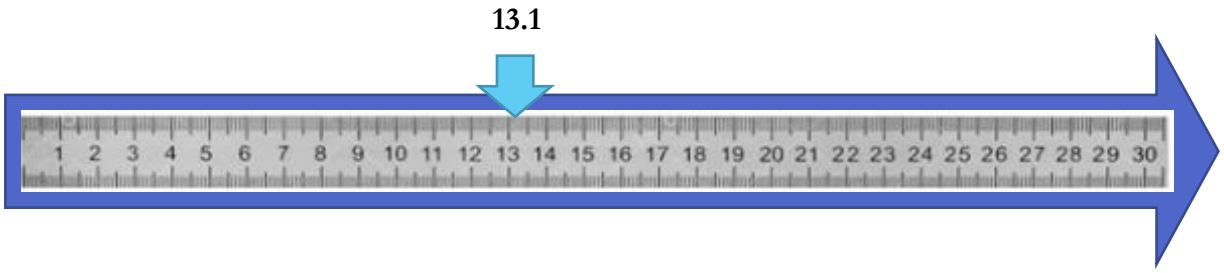
The Canadian Personal Recovery Outcome Measure (C-PROM) is a patient-reported outcome measure that has been designed and validated to assess recovery – the single most targeted outcome in mental health (Barbic & Rennie, 2016). It is a 30-item questionnaire that is to be completed by the individual at the beginning of each HH appointment. C-PROM can be used as an evaluative tool to capture change in the adjusted score over time; however, it is also meant to be used by clinicians to help guide conversation, assessment and goal setting.

Given clients are still participating in their HH journey, we cannot yet show the change in pre and post scores. The data below shows the average number of C-PROMs completed so far by 11 'A' clients and the average baseline score for those clients.

3 average number of completed C-PROMs per client



The average baseline C-PROM score was 13.1



Adult Resiliency

Mental health well-being is seen as a state of overall wellness that includes awareness and the effective use of strengths, abilities to cope and thrive. Resilience is commonly defined as an ability to bounce back from challenges and setbacks (Cool Family Solutions, n.d.). Cool Family Solutions uses **The Adult Resiliency: Social, Emotional Strengths Survey** to determine where people's strengths are upon entering the 10-week family support program and how those strengths have changed after the 10-week program.

The questionnaire is based on "the foundation of the Adult Resiliency Framework, which is based on the child, youth and adult resiliency assessment and developmental protocols, which promote a strengths-based approach and holistic framework for understanding the major components that contribute to individuals becoming both productive and responsible" (Resiliency Canada, n.d., p.1). The survey scores individuals from 0 to 100 according different developmental strengths and then categorizes that score as a significant challenge, moderate challenge, moderate strength or significant strength.

Significant Strength - scores of 75 or greater suggest that the person understands the strength area and actively use it in their life.

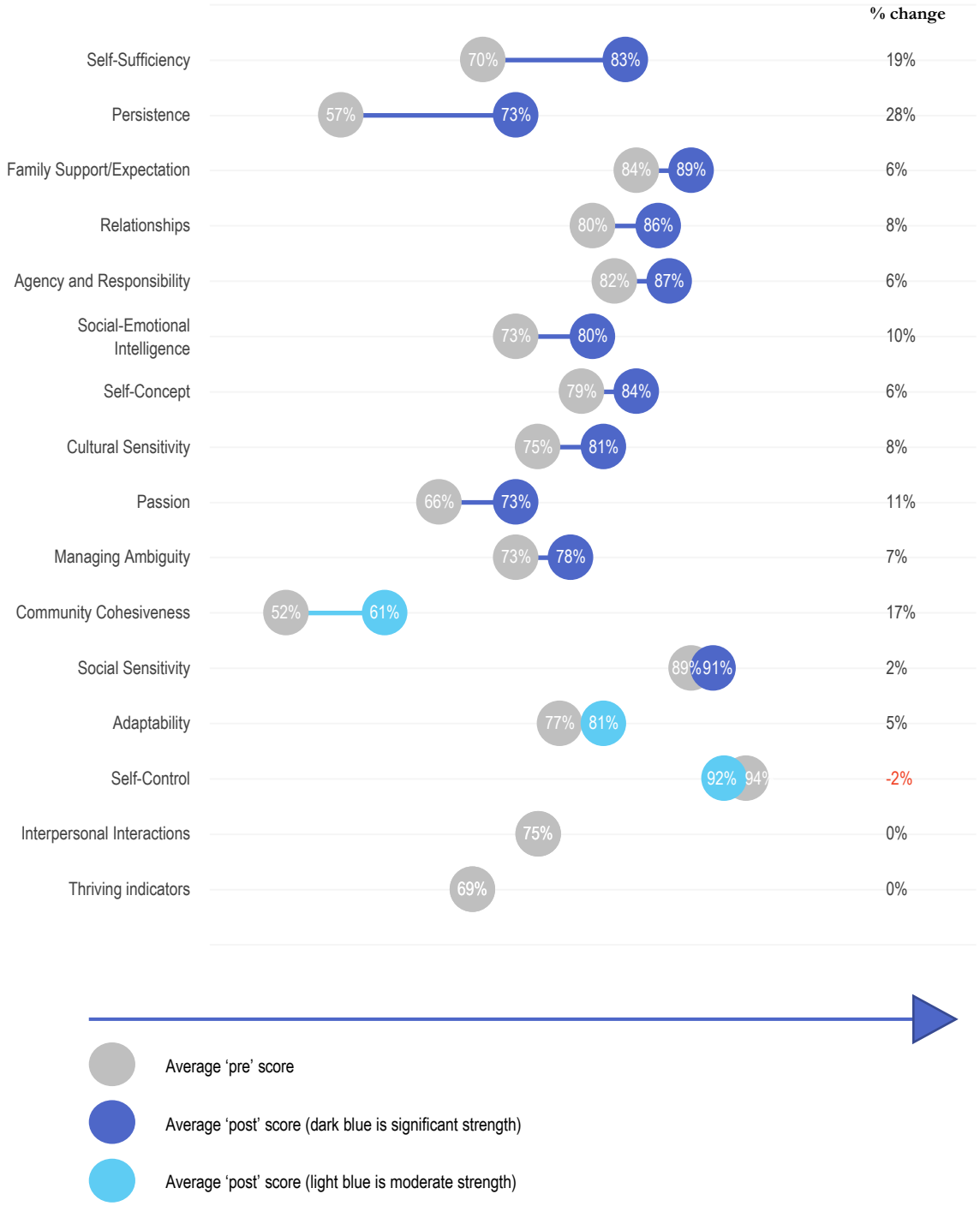
Moderate Strength - scores of 50 – 74 generally indicates that the person understands the strength and are starting to develop the strength in their life.

Moderate challenge - 25 – 49 implies that the person is becoming aware of the strength and are not currently using the strength in their life.

Significant challenge - suggests that the person is not aware of the strength nor have they established it in their life.

To date, HH has had nine people complete the survey from its most recent session. The results for the nine people who completed the survey are outlined on the next page.

Family members' average scores improved in all but 3 developmental strengths (self-control, interpersonal interactions and thriving indicators). The greatest improvement after the 10-week program was the average persistence score.



"I very much enjoyed the group. It has changed our family for the better and has made me a better parent and person. I wish we attended this group four years ago when our hell started. I think this should be widely available and advertise for all struggling families who could easily use the help to better themselves and their families." – Family Participant

Community Outcomes

To what extent did Harmonized Health enhance understanding of its model within the community?

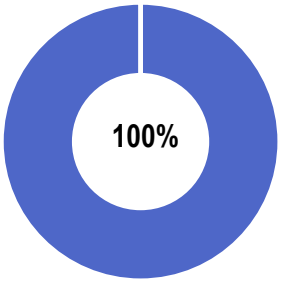
HH engages with community members and organizations by hosting local events. On October 24, 2020 HH hosted an event called, "The Language of Mental Health and Addiction – an interactive seminar with Dr. Raju Hajela." The purpose of the seminar was to help improve knowledge and understanding of mental health and addiction for HH personnel, clients and Airdrie community members. There were 23 attendees - 10 of those attendees were members of the HH operations and service provider team. Eight people completed the survey following the event. The results from that event's survey are as follows:

88% were likely to recommend this talk to a friend

Net Promoter Score

Promoters (9-10)	**88%**
Passives (7-8)	13%
Detractors (0-6)	0%

100% were 'very satisfied with the talk



What people like most about the talk…..

- *Reviewing the language understanding and discussions.*
- *He speaks in a very clear, easy to understand way. Very entertaining that includes humor and interesting anecdotes.*
- *The interaction and curiosity.*
- *Information provided – so interesting – and opportunity to hear people with lived experience.*
- *How related and easy he explained things.*
- *The amount of knowledge he shares.*
- *The learning opportunity for increased knowledge and understanding. The format of bringing together people with such a variety of backgrounds, experiences and reasons for being in attendance coming together to learn the biology and proper language behind addiction and mental health and how we can carry that knowledge and understanding into the community.*

Key Interim Findings and Recommendations

HH is a community-based pilot program that is intended to demonstrate the efficacy of a seamless and integrated approach between health care service providers and community peer supports. HH is at its halfway point. As such, this part of the evaluation was focused on defining and describing the model and to what extent it has been adopted in the first six months. Therefore, the recommendations are primarily targeted at the HH operations team to help make process improvements. Some early outcome data has been included; however, this will be explored toward the end of the program as the program is further implemented.

The Harmonized Health model

There are four pillars, components and partners that make up the HH model. Together, these elements are aimed at addressing the barriers and challenges expressed by community members and health care professionals with Alberta's mental health system. In particular, the need for a) more integration of services, b) greater knowledge and understanding of mental health and addiction and the available service and supports, and; c) a holistic, prevention-based approach. The elements of HH's model have been described in this report; however, what hasn't been addressed in this interim report are the specifics related to the service provider roles and the costs associated with the model – both will be addressed in the final evaluation report.

Recommendation: Determine the cost of HH and estimate the costs for ongoing supports post pilot. Outline in these costs the ongoing service provider and operational support that is needed, as well as the ongoing client costs.

HH began by focusing first on how to support integration of service providers to provide a more seamless, coordinated approach. Through local connections, HH was able to engage four organizational partners to work on HH: 1) HUM 2) Anchor of Hope 3) Care First Medical and 4) Cool Family Solutions. In November 2020, providers from these organizations completed a baseline assessment of their level of integration using the IPAT. At that point, the providers placed themselves at a Level 3 – Basic Collaborative Onsite care. The operations team and the evaluation consultant at the time also placed HH at a Level Three when they completed it.

"That's a part of the challenge has been getting these people to not just see themselves as their own individual agency. But to see themselves as combined that they're better off to be able to refer to each other. And it's a working product. We are not there yet clearly, but we've come a long way." – HH operations team member

When the IPAT was completed in November the team was still standardizing processes and systems across the various providers. The IPAT will be completed again toward the end of the program to see how integrated the providers are. In addition, interviews will be conducted with service providers to further explore enablers and barriers to integration. Interestingly, the operations team recently conducted the IPAT with participating physicians to include their perspectives; two of these physicians thought that the HH team was now at a Level Six – Full Collaboration in a Transformed/Merged Integrated Practice.

Recommendation: Explore with the HH service providers what it would take to move the team to a Level 6 on the IPAT. Work with the team to implement their suggested approaches and process improvements.

Recommendation: Conduct the IPAT again toward the end of the program to understand if the team has become further integrated. Interview service providers to understand the enablers and barriers to integration.

The HH operations team provides backbone support to the service providers. One aspect of that support is training. The HH team has conducted various training, including program, clinical and community supports training. HH has trained 20 people thus far and plans to continue training 16 people by the end of the program. The number and extent of training that is conducted is largely contingent on funding. For example, currently one physician from Care First Medical has engaged with the training modules at HUM (including completion of the first phase of IOP). It is budgeted for up to two further Care First Medical professionals to have similar training.

Recommendation: Continue/complete training programs underway or planned for professional and community team members. Consider incorporating a pre/post questionnaire to understand how training has supported knowledge and understanding of HH and its principles.

Recommendation: Continue with operations training for service providers and community supports in the interests of continuous improvement as well to identify gaps and recommendations for recording in final report.

Obtaining data for this evaluation highlighted that there are gaps when it comes to consistently entering client data; therefore, continuing to train and support the service providers in data capture processes will be important. HH has an operations coordinator who understands the HH databases and evaluation activities. In addition, this person has established relationships with the service providers, which will be be helpful when continuing to improve the consistency and reliability of the data.

Recommendation: Continue to work with service providers to encourage consistent documentation in AirTable and Nula.

Adoption of the model

Clients

As was described in this report, HH has evolved over time. Prior to its official start in August 2020, clients were receiving various aspects of the HH model. Overall, 119 people have received support from HH - 61 and 58 family members from 44 families. HH's target number of people to support through the program is 160. It expects to meet that target number by the end of the program, given the continued need for mental health supports.

The Canadian Mental Health Association (CMHA) recently released a report outlining the results of a survey that asked Albertans about the impact of COVID-19 on their mental health and well-being. The results indicated that COVID-19 caused significant challenges. The report also outlined mental health supports and resources as one of the most pressing future concerns for Albertans (Canadian Mental Health Association, n.d.). HH is experiencing the need described by the Canadian Mental Health Association. The program has funding for 12 individuals; however, HH recently onboarded four clients who have heard from others about HH and who wish to join the program. These are A Minus clients – the "Minus" refers to the absence of program funding.

HH has been tracking the journey of its A and A Minus clients through HH. Clients have begun their HH journey at various time points; therefore, some individuals have completed more appointments than others at this point. However, appointment data shows that the majority of clients are participating in their appointments; there does not appear to be frequent no-shows or withdrawal from the program. In addition, most clients (n=8) have completed their comprehensive assessments, while four clients are in progress. It will be important to continue to monitor to what extent individuals are participating in appointments as no-shows may indicate a program issue. In terms of family, there have been three family sessions since August 2020, each with 9-10 family participants (ten is the maximum number for each session). There is currently a waiting list for the next family session with eight people registered, which shows a demand for the family program.

Recommendation: Continue client care (professional and community supports) and evaluation plans already underway with *existing clients*. Complete those care plans already established and underway and have available full data suite from inception to completion.

Recommendation: Continue client care (professional and community supports) and evaluation plans for *future clients* as budget constraints allow. Provide care plans for client and have available full data suite from client experience.

Community

HH has engaged with several individuals and organizations. Kim, TUF's founder, is a long-time Airdrie resident who was instrumental in bringing together HH's four partner agencies; however, she continues to engage with social agencies, media, health services, government, foundations, academia and local business to help bring awareness to mental health and addiction and HH's work. Only one community event has been organized so far under the HH program. There were a reasonable number of attendees at the event, however a large portion were affiliated with HH (this seminar was part of the training for HH team members). The feedback from the event was positive, although again it is unclear if the survey results were from HH team members or others. The COVID-19 pandemic has understandably hindered any other in-person events; however, HH does intend to facilitate other community information sessions.

Recommendation: Develop a list of attendees and a communication and recruitment strategy for the community information sessions. Use the event to capture what information and connections people/organizations need and use that to build out the community strategy portion of the program.

Early Outcomes

Part of the HH operations team support is facilitating collection of evaluation data. As such, the team has done an exceptional job of identifying (or creating) data collection tools and administering those tools to capture baseline data; the IPAT is a good example of this. The HH operations team has also developed baseline individual and family experience surveys to capture clients' experience prior to HH. So far, only six individuals and eight family members have completed this survey so the findings should be interpreted cautiously. However, the findings do align with what was outlined in Valuing Mental Health report (Alberta Government, 2015) – people are not satisfied with the coordination of the care or the overall quality of care and most experience a number of challenges. The post survey has not been completed yet; however, these findings will be compared with the pre survey results to see if individuals and family members have an improved experience after participating in HH.

Knowledge and understanding

These baseline experience surveys also ask HH participants knowledge related questions related to HH's services and supports and its principles. The referral, initial assessment and information sharing process of the HH journey provides people with HH information; therefore, the baseline survey that is administered on intake is a good time to assess understanding. The results show that over half of HH clients were very clear on HH services and supports. Family members seem to have a better understanding of HH services and supports than individuals. Perhaps this is because there are fewer elements to the family side than for individuals. Regardless, there is likely opportunity to re-assess how HH provides information to individuals to further enhance understanding, particularly elements related to community supports and services. In addition, most individuals and family members seemed to understand and agree with HH's mental health and addiction principles.

Recommendation: Consider alternate communication mediums to enhance understanding of HH services and supports, particularly aspects related to community supports.

Client outcomes

HH uses the C-PROM as a recovery outcome tool. So far, individuals have completed an average of three C-PROMs. The average C-PROM score is 13.1 According to Barbic and Rennie (2016) a C-RPOM score of 13 means that individuals are presenting in the middle range where generally 40% of the population will score. These middle scores mean people may benefit from care that is targeted at self-esteem and managing stress (Barbic & Rennie). When there is more C-PROM data it will be useful to further analyze where, and what proportion of individuals, are scoring along the C-PROM continuum. Having a better understanding of the C-PROM data may help to guide service planning. For example, if most individuals are scoring in the middle range, then services and supports should be directed at enhancing self-esteem and managing stress.

Recommendation: Review with service providers the process for administering and entering C-PROM data.

Recommendation: Consider how the existing services and supports align with the C-PROM data that is gathered.

Family outcomes are assessed using a resiliency survey. Comparison of the pre and post scores shows that family members are having improved outcomes in almost all developmental strengths following the 10-week family program. The greatest improvement in scores was related to self-sufficiency and persistence. The feedback from family members on their 10-week program was very positive. It will be important to continue capturing outcome data and participant feedback as more participants complete family sessions.

Recommendation: Continue to administer the adult resiliency questionnaire. Review to what extent the program does or does not align with the developmental strengths.

Conclusion

HH has designed a community addiction and mental health model that is now at the interim point of implementation. At this point, service providers are working collaboratively, and clients are participating in its various elements. Early outcome data from family members is positive and shows improvement in most resiliency scores. Individual outcome data is limited at this point given individuals are still participating in HH.

HH's model operates with two notable assumptions that will need to be addressed going forward: 1) that there is an HH operations team and volunteers to support implementation (e.g., training, data management, process improvements, even some elements of the intake process), and; 2) client care is funded (i.e., clients do not pay for their HH care). Given these important elements, HH is beginning to prepare a plan of action for ongoing continuity of the HH program.

There are 13 recommendations outlined in this report. Many of the recommendations are targeted at process improvements the HH operations team can make in the next stage of the program. The next stage of the evaluation will focus on measuring and describing how effective the model is in supporting people with mental health and addiction challenges.

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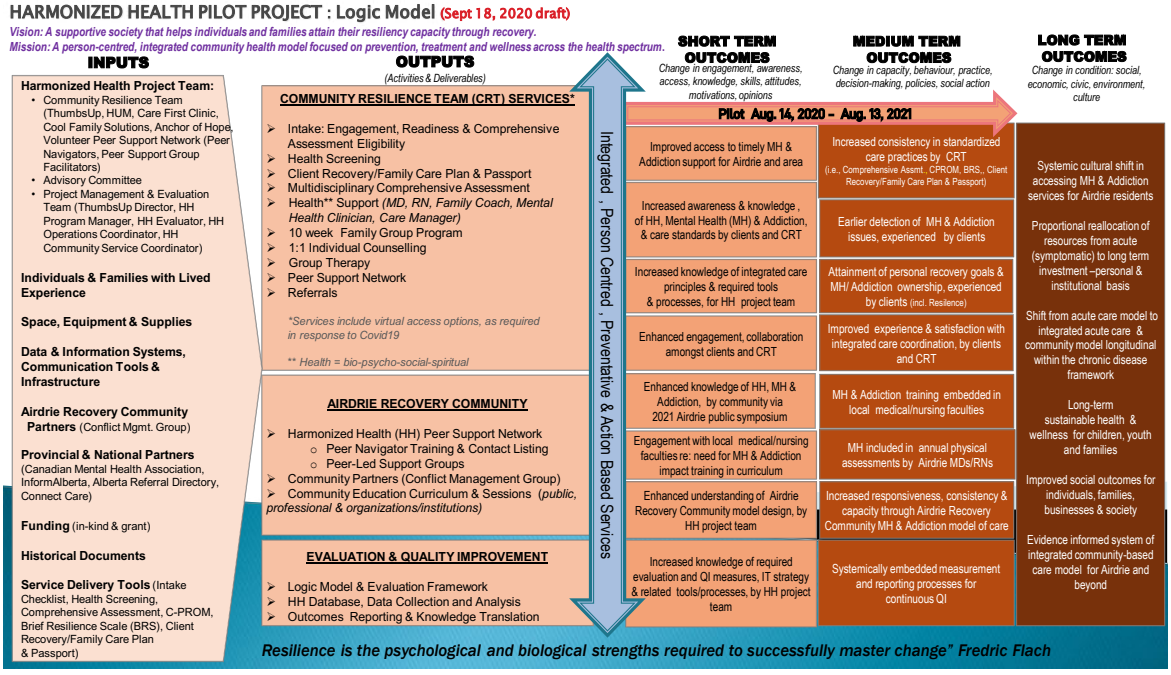
Appendices

Appendix A:


HARMONIZED HEALTH PILOT PROJECT : Logic Model (Sept 18, 2020 draft)
Vision: A supportive society that helps individuals and families attain their resiliency capacity through recovery.
Mission: A person-centred, integrated community health model focused on prevention, treatment and wellness across the health spectrum.
INPUTS
Harmonized Health Project Team:
Community Resilience Team (ThumbsUp, HUM, Care First Clinic, Cool Family Solutions, Anchor of Hope, Volunteer Peer Support Network (Peer Navigators, Peer Support Group Facilitators)
Advisory Committee
Project Management & Evaluation Team (ThumbsUp Director, HH Program Manager, HH Evaluator, HH Operations Coordinator, HH Community Service Coordinator)
Individuals & Families with Lived Experience
Space, Equipment & Supplies
Data & Information Systems, Communication Tools & Infrastructure
Airdrie Recovery Community Partners (Conflict Mgmt. Group)
Provincial & National Partners (Canadian Mental Health Association, InformAlberta, Alberta Referral Directory, Connect Care)
Funding (in-kind & grant)
Historical Documents
Service Delivery Tools (Intake Checklist, Health Screening, Comprehensive Assessment, C-PROM, Brief Resilience Scale (BRS), Client Recovery/Family Care Plan & Passport)
OUTPUTS
(Activities & Deliverables)
COMMUNITY RESILIENCE TEAM (CRT) SERVICES*
Intake: Engagement, Readiness & Comprehensive Assessment Eligibility
Health Screening
Client Recovery/Family Care Plan & Passport
Multidisciplinary Comprehensive Assessment
Health** Support (MD, RN, Family Coach, Mental Health Clinician, Care Manager)
10 week Family Group Program
1:1 Individual Counselling
Group Therapy
Peer Support Network
Referrals
*Services include virtual access options, as required in response to Covid19
** Health = bio-psycho-social-spiritual
AIRDRIE RECOVERY COMMUNITY
Harmonized Health (HH) Peer Support Network
Peer Navigator Training & Contact Listing
Peer-Led Support Groups
Community Partners (Conflict Management Group)
Community Education Curriculum & Sessions (public, professional & organizations/institutions)
EVALUATION & QUALITY IMPROVEMENT
Logic Model & Evaluation Framework
HH Database, Data Collection and Analysis
Outcomes Reporting & Knowledge Translation
Integrated , Person Centred , Preventative & Action Based Services
SHORT TERM OUTCOMES
Change in engagement, awareness, access, knowledge, skills, attitudes, motivations, opinions
MEDIUM TERM OUTCOMES
Change in capacity, behaviour, practice, decision-making, policies, social action
LONG TERM OUTCOMES
Change in condition: social, economic, civic, environment, culture
Pilot Aug. 14, 2020 – Aug. 13, 2021
Improved access to timely MH & Addiction support for Airdrie and area
Increased consistency in standardized care practices by CRT (i.e., Comprehensive Assmt., CPROM, BRS,, Client Recovery/Family Care Plan & Passport)
Systemic cultural shift in accessing MH & Addiction services for Airdrie residents
Increased awareness & knowledge , of HH, Mental Health (MH) & Addiction, & care standards by clients and CRT
Earlier detection of MH & Addiction issues, experienced by clients
Proportional reallocation of resources from acute (symptomatic) to long term investment –personal & institutional basis
Increased knowledge of integrated care principles & required tools & processes, for HH project team
Attainment of personal recovery goals & MH/ Addiction ownership, experienced by clients (incl. Resilience)
Shift from acute care model to integrated acute care & community model longitudinal within the chronic disease framework
Enhanced engagement, collaboration amongst clients and CRT
Improved experience & satisfaction with integrated care coordination, by clients and CRT
Long-term sustainable health & wellness for children, youth and families
Enhanced knowledge of HH, MH & Addiction, by community via 2021 Airdrie public symposium
MH & Addiction training embedded in local medical/nursing faculties
Improved social outcomes for individuals, families, businesses & society
Engagement with local medical/nursing faculties re: need for MH & Addiction impact training in curriculum
MH included in annual physical assessments by Airdrie MDs/RNs
Evidence informed system of integrated community-based care model for Airdrie and beyond
Enhanced understanding of Airdrie Recovery Community model design, by HH project team
Increased responsiveness, consistency & capacity through Airdrie Recovery Community MH & Addiction model of care
Increased knowledge of required evaluation and QI measures, IT strategy & related tools/processes, by HH project team
Systemically embedded measurement and reporting processes for continuous QI
Resilience is the psychological and biological strengths required to successfully master change" Fredric Flach

Appendix B: Data Sources and Methods

Client administrative data

HH uses two databases to capture client data - AirTable and Nula. Service providers enter clinical information into both databases. Nula is where clinical information is captured and AirTable houses HH program specific variables (e.g., demographics, participation in HH program elements). For the purposes of this evaluation, some information (e.g., C-PROM) scores needed to be exported from Nula and merged with AirTable data. The HH operations administrator merged the data into an 'Individual' Excel spreadsheet and a 'Family' Excel spreadsheet. She then worked with the service providers to fill in the gaps in data. The family data was entered consistently and reliably; however, the individual data, particularly historical client data (Category B and C) had many gaps. The HH operations administrator is working to obtain and enter this historical information for a more complete dataset for future reporting.

Three Hive cleaned and analyzed the data in Excel. Descriptive analysis was done using Excel Pivot Tables and Pivot Charts.

Interview data

For this phase of the evaluation, we invited two people from the HH operations team to participate in a semi-structured interview. The purpose of the interview was to understand HH's background and how it has evolved over time. The participants were given the choice to a) participate, and b) to participate in one shared interview or two separate interviews. They chose to be interviewed together. The interview was recorded and transcribed using Microsoft Teams. The transcript was reviewed and cleaned. The transcript was uploaded and coded using ATLAS.ti. Conventional content analysis was used to code the transcript. Coded data was used throughout the report where relevant. This interview will be themed with the other HH interviews when they are conducted.

Individual and family experience survey data

The individual and family experience surveys were developed by the HH operations team and the previous evaluation consultant. The surveys have been uploaded to SurveyMonkey. Six individuals and eight family members completed the surveys. The HH team exported the SurveyMonkey data into Excel. Three Hive used the pre-generated tables in Excel to generate the charts used in the report.

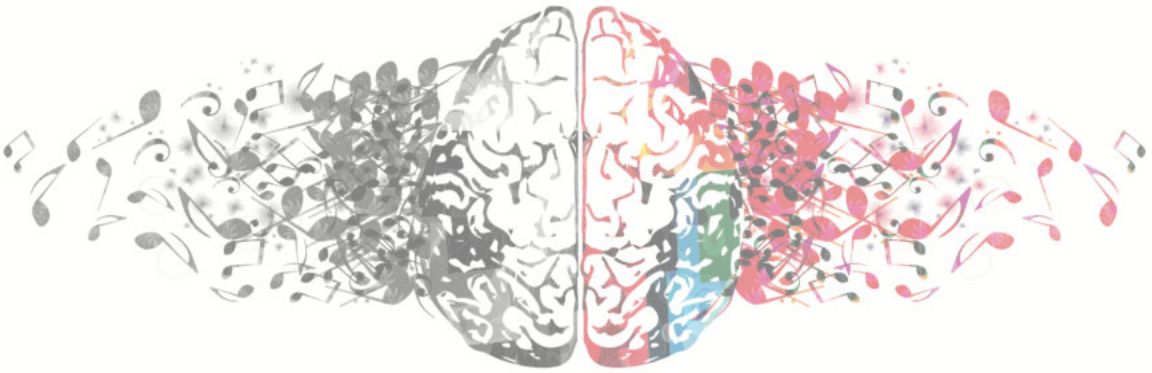
Results to one question that outlined various HH services and supports were aggregated into two categories: 1) Professional Supports, and 2) Community Supports. Comprehensive Assessment, a Recovery Care Plan and Passport, Multidisciplinary Health Supports, 10-week family program, counseling and referrals to other community services were aggregated into the "professional supports" category.

Conversation with a peer, peer navigation and support and Airdrie Recovery Community supports were aggregated into the "community supports" category.

While the response rate to the survey was good, there is only a small number of people who have responded to the survey at this point. Therefore, it will be important to continue administering the survey to all participants and encouraging completion of it.

Other sources of data

HH has captured data from other tools including the The Adult Resiliency: Social, Emotional Strengths Survey, the Integrated Practice Assessment Tool, the Canadian Personal Recovery Outcome Measure (C-PROM) and a survey they administered following the HH community event. For more details on each of these tools refer to the respective sections in the body of this report.



Prepared by:

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