HARMONIZED HEALTH

Pilot Project Final Evaluation Report

SEPTEMBER 2021

ThreeHive CONSULTING

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Executive Summary

Introduction

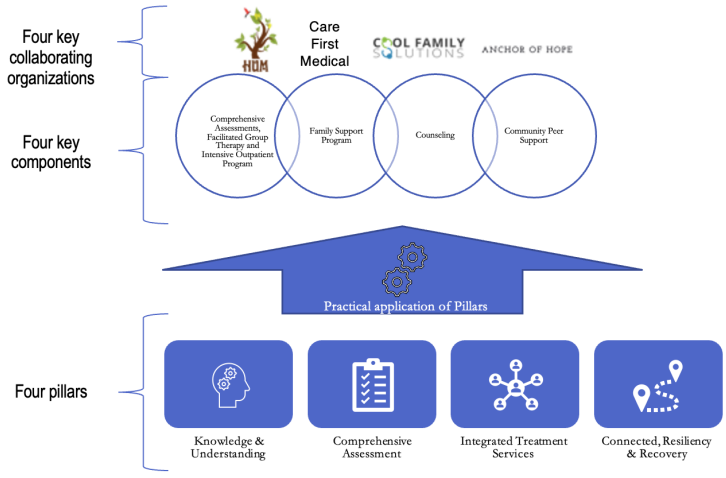
Harmonized Health (HH) is one of the feature initiatives of the Thumbs Up Foundation (TUF), a foundation established to advocate for positive change for mental health. HH is intended to be a new, different, and more effective way of supporting people with mental health and addiction challenges. HH aims to provide seamless, integrated care that puts people first, as opposed to being constrained by system priorities and processes. The aim is not to replace, but rather to complement existing community services, connecting clients aged 16 and older with mental health and addiction challenges to available local resources, from prevention through the continuum of care. Its "people first" approach is intended to result in improved individual and health system outcomes.

The need for improved individual and health system outcomes in Alberta's mental health systems is well established. 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 or didn't receive enough service (Alberta Government, 2015). The long-term impacts of not meeting the increasing mental health needs will have many social and financial ramifications including more people living with disability, shorter life expectancies, increased struggles with housing and homelessness, and increased incarcerations (Mental Health Commission of Canada, 2017).

Evaluation Overview

This final evaluation report describes outcome data from clients, service providers and operation team members to understand adoption and effectiveness of the 12 month HH Pilot Project. The report also identifies recommended next steps beyond the pilot phase. This evaluation used a mixed methods approach. HH administrative data was used to report activity and outcome data for clients (both individuals and family members) who participated in HH. In addition, pre and post appraisal client survey data was collected and reported on in this report. The quantitative data was supplemented with HH client, service provider and operational team interview data. Certain clients also submitted stories of change – two of which are included in this report.

Harmonized Health Pilot Project Overview



Key Findings & Recommendations

There were six key findings and corresponding recommendations from this pilot project evaluation. As HH continues to develop the following strengths and areas for development should be considered.

Key Finding #1 – The Harmonized Health Pilot Project offered a more person-centred model of care.
HH clients, service providers and the operations team discussed how HH is different from traditional mental health and addiction models. These stakeholder groups felt that HH offered a more 'personalized' or 'person-centred' approach to care than traditional mental health models. Clients described feeling listened to and a greater sense of trust with service providers in their HH journey than they had experienced in the past. Many clients described more satisfaction and success with their HH journey than they had experienced when accessing other mental health services in the past.

Client journey data showed that each person's journey through HH differed. Clients and service providers valued the personalized nature of HH care; however, it also meant that the HH journey and processes were sometimes unclear.

Recommendation 1: Continue to offer a person-centred model, which is adaptable to client needs, while formalizing some aspects of the HH client care pathway(s). Work with service providers to refine communication of the HH journey and processes for clients.

Key Finding #2 – Collaborating organizations and their service providers operate differently.
HH collaborating organizations offer approaches and content that are different from the existing system. Clients felt that HH service providers had an elevated level of expertise and more experiential knowledge from what they had experienced before. Service providers and the operations team thought the collaborating organizations offered more effective programs than other community based mental health and addiction programs. The family program offered by Cool Family Solutions was described by clients, service providers and the operations team as a unique aspect because it focuses on family members as opposed to the individuals dealing with mental health and/or addiction struggles. Understanding the shared values and principles of care among the collaborating organizations will be important in supporting integrated care.

Recommendation 3: Identify core values and principles that underpin how HH, and its collaborating organizations operate.

Key Finding #3 – Integrated care is important but was not achieved.
The HH Pilot Project worked to facilitate collaboration between the organizations. This collaboration required considerable effort but the full integration it had intended was not achieved. Individuals, service providers and the operations team recognized the traditionally siloed approach to care and the need for a more integrated approach. However, integration was hindered by operational and systemic barriers that resulted in service providers not fully adopting the HH Pilot Project model.

Recommendation 2: Seek out expertise to help provide leadership and coaching on healthcare change management.

Key Finding #4 – A Coordinator role is essential and requires further clarity and development.
The Coordinator role was viewed as important by clients, service providers and the operations team. In addition, HH data shows that this role takes on a variety of responsibilities. Clients appreciated how the Coordinator proactively called and checked in on them, but also advocated for them. The TUF founder acted in this role temporarily for the purposes of the pilot project. Going forward, it will be important to determine a) who will take on the responsibilities of this role post-pilot, and; b) what training they will receive.

Recommendation 4: Identify where the role and responsibilities of the Coordinator role should be transitioned to and the type of training that person(s) should receive.

Key Finding #5 – An integrated system is needed to support quality improvement, evaluation and integrated client care.
Having systems and processes that support monitoring of clients' activity and outcomes is important for quality improvement and evaluation purposes. In addition, clients expressed how they liked monitoring their progress by completing the outcome measures. However, service providers felt that additional data and systems to record that data (Nula and AirTable) was burdensome. Service providers felt that integrated EMRs - although outside the scope of this pilot project – were needed to support integration.

Recommendation 5: Work with collaborating organizations to establish agreed upon systems and processes for capturing client activity and outcome data.

Key Finding #6 – Cost is a barrier to entry.
One of the underlying assumptions of the HH Pilot Project model was that cost is a barrier to entry. Clients, service providers and operations team members validated this assumption in the evaluation by indicating that clients could not afford HH care or would be less likely to seek and sustain care if they needed to fund it on their own. To mitigate this barrier, client care was funded for 12 clients (Category A) as part of the pilot project. During the pilot project there was additional demand for care and 21 Category A Minus clients were provided care; these costs were/are funded by TUF. After removing operational costs, the estimated "all in" average HH cost per person was approximately $2100.

Recommendation 6: Determine how to secure or reallocate funding to cover the operational and client costs.

Summary

Transforming how mental health and addiction care is delivered is complex. Complexity means there is high uncertainty about what works, disagreement even about the nature of a problem, no right answers, and nonlinear interactions within a dynamic system (Patton, 2010). Creating a setting that is conductive to innovation means having strategies that set a clear and firm direction, but are flexible, adaptable, and responsive to changing conditions and contexts and that allow for the emergence of a continually improving model (Antwi and Kale, 2014). As next steps for HH are explored the six recommendations listed above should be considered as next steps to further develop and adapt HH.

Introduction

Harmonized Health (HH) is one of the feature initiatives of the Thumbs Up Foundation (TUF), a foundation established to advocate for positive change for mental health. 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 first, as opposed to being constrained by system priorities and processes. The aim is not to replace, but rather to complement existing community services, connecting clients aged 16 and older with mental health and addiction challenges to available local resources, from prevention through the continuum of care. Its "people first" approach is intended to result in improved individual and health system outcomes.

This final evaluation report describes outcome data from clients, service providers and operation team members to understand adoption and effectiveness of the 12 month HH Pilot Project. The report also identifies recommended next steps beyond the pilot phase.

Background

The need for improved individual and health system outcomes in Alberta's mental health systems is well established. 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 or didn't receive enough service (Alberta Government, 2015). 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, delays, and inadequate treatment (Alberta Government, 2015). Unfortunately, the COVID-19 pandemic has exacerbated the need for mental health and addiction care. A recent survey by the Canadian Mental Health Association – Alberta Division (2020) identified ongoing, increased mental illness and mental health problems as one of the most pressing future concerns for Albertans. The long-term impacts of not meeting the increasing mental health needs will have many social and financial ramifications including more people living with disability, shorter life expectancies, increased struggles with housing and homelessness, and increased incarcerations (Mental Health Commission of Canada, 2017).

TUF identified the increasing need to advance positive change for mental health in Alberta. In 2015, it began engaging with other people and organizations who were also trying to address mental health and addiction concerns. TUF engaged with four formative organizations:

1) **Cool Family Solutions** (CFS)
2) **Anchor of Hope** (AOH)
3) the **Foundation for Addiction and Mental Health** (FAMH)
4) **Health Upwardly Mobile** (HUM)

In 2020, the HH Pilot Project received Alberta Health funding to explore a community model. Both the funder and TUF outlined evaluation as a necessary component of the HH Pilot Project.

Evaluation Overview

TUF prioritized evaluation as an important element of the HH Pilot Project. In August 2020, an external evaluator worked with HH to refine and define the program vision and mission, as well as develop a program logic model. In December 2020, Three Hive Consulting ("Three Hive") was contracted to continue the evaluation. Three Hive outlined an evaluation process that aimed to address the following evaluation questions for the HH Pilot Project:

Evaluation Question 1: What is the Harmonized Health model of care?
Evaluation Question 2: To what extent has Harmonized Health 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?

In February 2021, Three Hive analyzed and reported data that had been collected until January 2021 in a Harmonized Health Interim Evaluation Report (Three Hive Consulting, 2021). The interim evaluation report focused on defining and describing the HH model and the extent to which it had been adopted in the first six months (evaluation questions 1 and 3), primarily using quantitative data. Early outcome data from family members was positive and showed improvement in most resiliency scores; individual outcome data was limited. This report focuses primarily on qualitative outcome data collected from clients, service providers and operation team members to understand adoption and effectiveness of the HH mode of care.

Data Sources

This evaluation used a mixed methods approach. The following table presents a list of data sources used for this evaluation report. Refer to : Data Sources and Methods for a more detailed description of the methods.

Data Source	Overview
HH databases	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 specific variables (e.g., demographics, participation in HH program elements). In addition to these two databases, an "HH Management" spreadsheet was used to capture the ongoing events/interactions (e.g., emails, text) of the HH Coordinator.
Client stories of change and virtual interviews	Clients (individuals and family members) were invited to submit stories about their experience with HH. Clients were provided with six question prompts and asked to either write their story using these questions as a guide or record a five-minute voice or video recording. Clients who consented were then contacted by the evaluation team and invited to participate in a short interview. Five individuals submitted their written story (two are highlighted in this report). No family members submitted their story. There were eight individual semi-structured interviews and eight family member interviews conducted. Two of the family interviews had two family members interviewees in the interview.
Experience surveys	Clients (individuals and family members) were given a baseline survey upon intake and a post appraisal survey at program completion. Six individuals and eight family

Data Source	Overview
	members completed the baseline surveys. Ten (out of 12) individuals completed the post appraisal survey, and 43 family members completed the post appraisal survey.
Client outcome measures	The Canadian Personal Recovery Outcome Measure (C-PROM) is a patient-reported outcome measure to assess recovery. It is a 30-item questionnaire that is to be completed by the individual at the beginning of each HH appointment. The Adult Resiliency: Social, Emotional Strengths Survey is used 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.
Service provider and operations team virtual interviews	Service providers (n=7) and operations team members (n=3) were invited to participate in a one-on-one semi-structured interviews with an evaluation team member. Ten people, representing the operations team and each of the organizations involved in HH, were invited and all agreed to participate.

Terminology

The terms "clients," "individuals" and "family members" will be used throughout this report. For this report, "clients" includes both individuals and family members. "Family members" are people who participated in the Cool Family Solutions family program. "Individuals" includes the people categorized according to the definitions in the callout box below.

Individuals are grouped into four categories. These categorizations help to differentiate the level and type of service people have received over the years (clients in the HH Pilot Project and pre HH Pilot Project).

Category Definitions

CATEGORY 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.

CATEGORY A Minus: The "minus" indicates an absence of program funding. These are people who have heard from others about HH and 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.

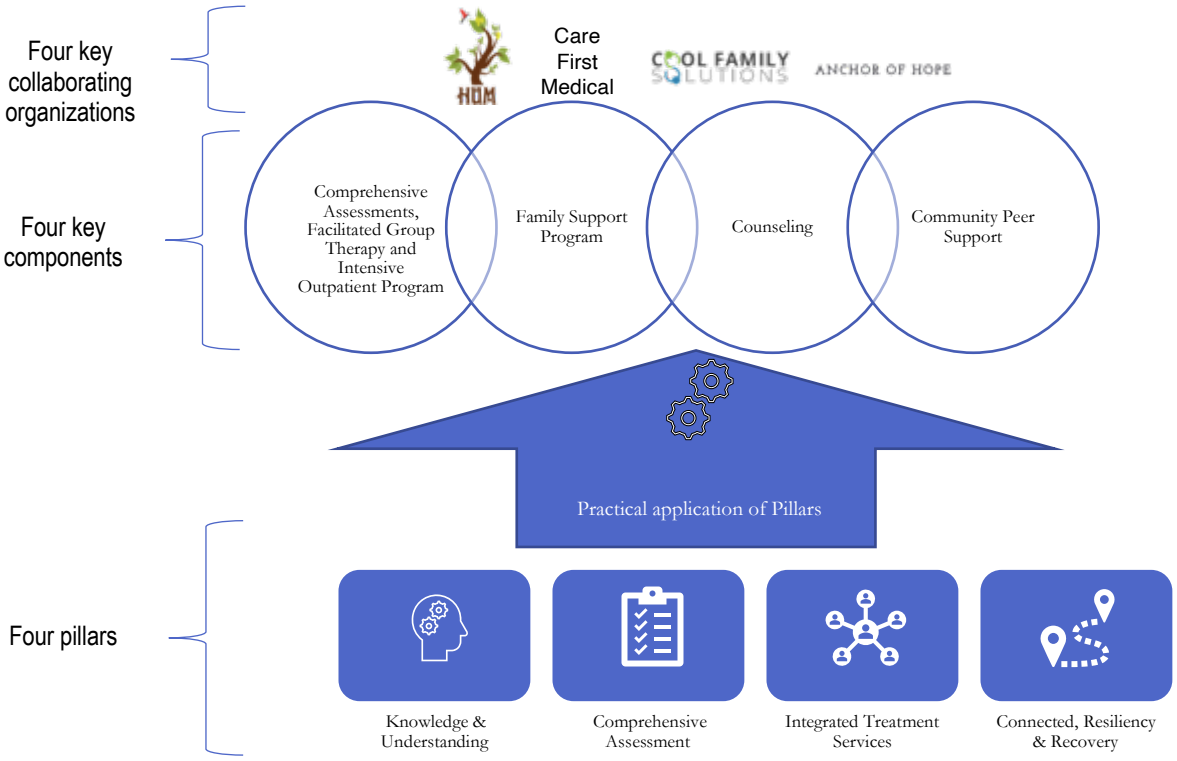
CATEGORY B: Individuals or family members who have prior to August 14th, 2020 availed themselves of one or more of the services developed at that time by HH.

CATEGORY 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.

An Overview of Harmonized Health

Elements of the Harmonized Health Pilot Project Model

The HH model of care is a community mental health and addiction model designed around four pillars, operationalized by four collaborating organizations, and delivering four key components (see figure below).



Four Key Collaborating organizations

The four collaborating organizations linked under the HH umbrella are described below:

Health Upwardly Mobile (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 HUM developed to fully explore a person's history, their symptoms, and the acuity of their issues. HUM provides a team approach to psychotherapy. HUM also provided some training to other HH service providers (e.g., Care First Medical physicians).

Care First Medical

Care First Medical (CFM) is a family practice medical clinic in Airdrie. Staff and two physicians from CFM participated in the HH Pilot Project.

Anchor of Hope (AOH) is an organization that offers counselling services, recovery in addiction, and individual and group therapy (Anchor of Hope, 2021).

Cool Family Solutions (CFS) is an organization focused on supporting families with loved ones struggling with mental health and addiction (Cool Family Solutions, 2018). They offer a ten-week program that focuses on equipping family members with strategies to engage in honest conversations about difficult situations, regardless of their loved one's state of readiness for change.

Backbone support

The HH operations team supported the four HH collaborating organizations and was comprised of two Project Leads, an Operations Coordinator, Peer Coordinator and Project Assistant. The backbone supports they provided included:

1) HH training to support aligned activities (see HH Interim Evaluation Report for more details related to training);
2) Project management and coordination services;
3) Monitoring and evaluation support; and
4) Quality improvement support for the collaborating organizations.

Coordinator Role

One of the Project Leads (the TUF founder) acted in the Coordinator Role upon the recommendation of a HH Advisor and the previous evaluation firm. The TUF founder acted in this role temporarily for the purposes of the pilot project. This recommendation was based primarily on two considerations: 1) this position was not budgeted for in the pilot project grant application, and; 2) there were only a limited number of clients who funded for the pilot project, which meant broadly advertising the pilot could result in a situation where demand exceeded supply. TUF was known in the community and therefore had the ability to provide outreach and recruit potential clients.

The Coordinator was responsible for receiving referrals, conducting the initial conversations whereby information about HH was shared, and supporting clients in their decision of whether or not to participate in the HH Pilot Project. After reviewing the Coordinator's activities captured in the HH Management spreadsheet, it is evident that this role also served other functions. The Coordinator also initiated referrals to appropriate programs or other key HH contacts (i.e., CFM for intake), helped *coordinate* completion of baseline surveys, gathered testimonials and received feedback on HH experiences. A significant portion of

this role is in client support: participating in active listening, validation and "check-ins," and providing ongoing offerings of support.

The specific tasks that the Coordinator did were captured as events in a spreadsheet. Events included texts and emails that were exchanged between the Coordinator and the client or the client's referral contact. These events were grouped into the following six tasks.

Event Type	Description of events	% of total events (approximate)
1. Sending information	The Coordinator sends information, usually over email.	~8%
2. Responding to requests for information	Several incoming events request information about HH or services offered.	~9%
3. Logistic support	Communication events to set up an in-person meeting or time to chat on the phone.	~20%
4. Liaison	The Coordinator acts as a connector, making introductions or liaising people with other programs, people and services.	~6%
5. Surveys	The Coordinator reminds clients about or receives completed baseline surveys.	~13%
6. Testimonials	The Coordinator requests or receives an individual's testimonial about their experience.	~6%
7. Feedback	Clients express gratitude or provide positive feedback about their experience in the program, unrelated to a testimonial.	~5%
8. Follow-up	A significant portion of communication events is attributed to following-up or checking in with previous contacts. These follow-ups can result in lengthy discussions, often with an offer of support.	~30%

Community Peer Support

HH also offers community peer support in addition to the professional services offered through its collaborating organizations. Its community and peer support element are intrinsic, unique components of HH. The peer element of HH is available through three main types of community peer support:

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.

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.

Peer Group Facilitator – A community member with sufficient experience or training to organize and facilitate a small group (or groups) of HH clients for regular recovery meetings.

Harmonized Health Costs

Mental health and addiction care can be costly and a barrier for some to seek help (Alberta Government, 2015). Recognizing this barrier, the HH Pilot Project has fully funded the HH services. The various HH care elements that have been funded for individuals and a breakdown of those approximate costs are included in the table below.

HH Care Element	Cost Per Person
Comprehensive Assessment	$600
10 Week Family Support Course	$300
Course of 10 individual counselling sessions	$1500
Course of 12 group psychotherapy sessions	$70 per session
Intensive Outpatient Program	$5000
Community Peer Supports	Nominal

The estimated "all in" average HH cost per person served to date is approximately $2100 (after removing project operational costs).

Client Experiences & Outcomes

Who does Harmonized Health care for?

121

is the number of people served by Harmonized Health

There have been **50 individuals** served through Harmonized Health; 12 of those individuals were part of the HH Pilot Project

Category*	Total people
Category A	12
Category A Minus	21
Category B	17
Category C	0
TOTAL	**50**

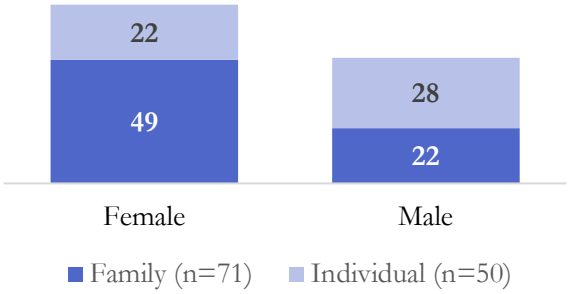
*Refer to Category definitions on page 3.

There have been **71 family members** served through Harmonized Health. Five sessions were part of the HH Pilot Project.

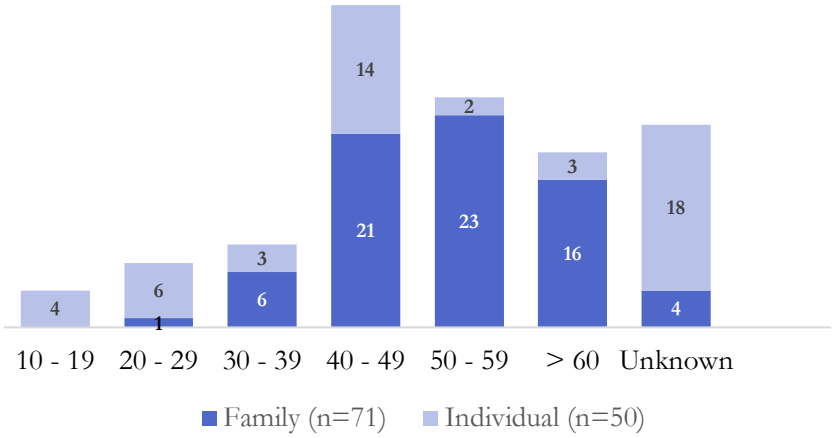
Session start date	Total people
November 13, 2018	3
May 28, 2019	12
October 30, 2019	9
November 11, 2020	9
February 10, 2021	10
March 23, 2021	10
March 25, 2021	8
June 3, 2021	10
TOTAL	**71**

Client demographics

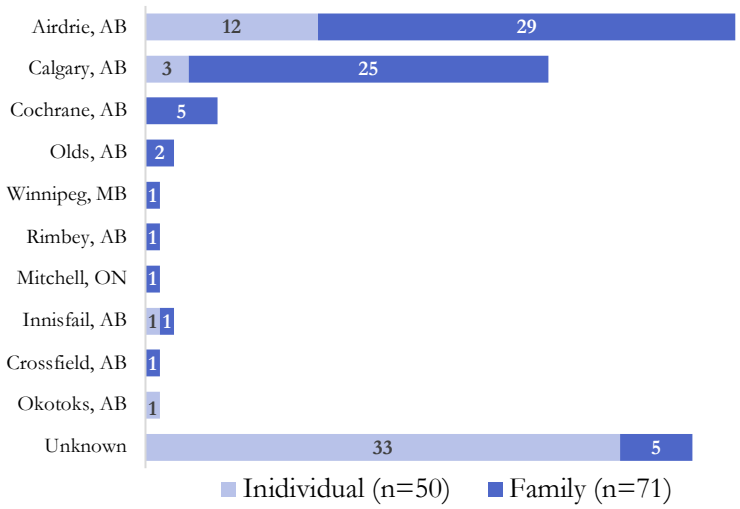
There were more female family members, but more male individual clients



Most clients were between 40 – 59 years of age



Many clients were from Airdrie; however, a large amount had no documented city

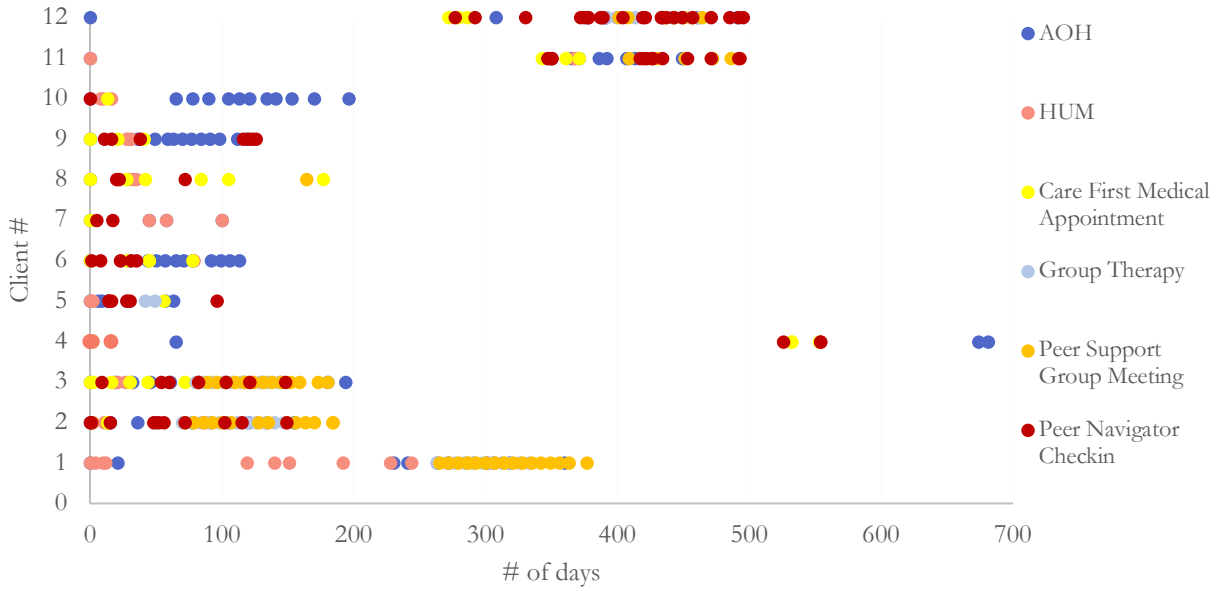


What is the client's experience with Harmonized Health?

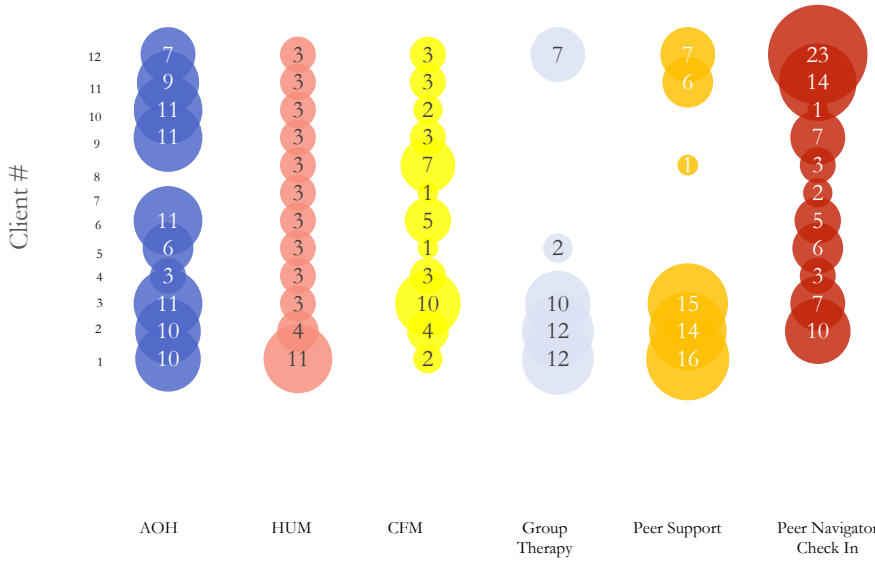
Harmonized Health Journeys

The following charts show that each individual's journey through HH is different. The first chart shows the number and type of visits each Category A client attended over time (in number of days). Each dot represents one visit date. Some of the dots are overlapping; therefore, the second chart shows the total number of visits, according to visit type, for each client – the larger the bubble the higher the number of visits.

The Harmonized Health journey is not uniform; it differed for each Category A client.



Each Category A client had varying numbers of visits with each Harmonized Health elements. With the exception of two clients, most had 3 visits to HUM.



Client Interviews & Survey Data

Clients were invited by the service providers to participate in a one-on-one semi-structured interview with an evaluation team member. For clients who replied to the invitation and consented to be interviewed, an evaluation team member followed up to schedule the virtual interview. Eight interviews with individuals were conducted and seven interviews with family members. Themes from the client interviews are explored below.

In addition, relevant individual and family experience pre- and post-appraisal survey data is highlighted. In total there were 14 clients who completed the pre survey (6 individuals and 8 family members) and 53 clients who completed the post appraisal survey (10 individuals and 43 family members).

Previous experiences with the mental health system

All clients (individuals and family members) reflected on their experiences with mental health and addiction care prior to HH. When discussing the care, they tried to access (or tried to access for their family member), nearly all spoke about how it was ineffective. Ineffective care was most often characterized as *difficult to access*, *lacking continuity* and being *depersonalized*.

Pre- Experience Survey Finding

86% (n=12) of *clients* (individuals and family members) said prior to HH they were moderately, slightly, or not at all satisfied with the **quality of care they or their loved one received.** No clients were completely satisfied and only 14% were very satisfied.

Lack of Accessibility

When respondents talked about trying to access mental health and addiction services prior to HH, they talked about difficulties navigating and accessing the care they needed when they needed it. When people did find services, they thought they or their family member needed, they discussed cost as a barrier. For example, some talked about how there are limits on the number of appointments allowed, and when that limit was reached, they needed to find care elsewhere.

Pre-Experience Survey Finding

58% (n=5) of *clients* (individuals and family members) said prior to HH care always, almost always or usually cost too much.

"Cost was always a huge thing because you could do one-on-one sessions with certain groups and then obviously your benefits would be done and then all of a sudden you were left to hold that whole cost on your own, right? And in some cases, that wasn't just – that wasn't feasible."

Discontinuity

Pre- Experience Survey Finding

71% (n=10) of *clients* (individuals and family members) said that prior to HH they had to always or almost always repeat important details of their or their loved one's care to different care providers.

Respondent's experiences prior to HH were characterized by short, episodic care. Some attributed the discontinuity to the costs of care. Some described experiences accessing acute care in inpatient settings; they spoke of getting well, but then reverting to past behaviour after discharge.

"I would go, and I would get well while I was there. And then, not shortly after, I would leave [and] I would get right back at it because you're - I guess they don't stay connected with you."

Depersonalized

Many respondents described the care they had previously received as being depersonalized. Many respondents used the phrase "just another number" to describe how they felt while being treated in the existing mental health system. Many discussed feeling like they were not being listened to; some mentioned feeling stigmatized. Generally, respondents noted interactions with service providers that were unempathetic and discompassionate. Some respondents talked about "pill pushing" and how service providers' solution is to "pill it out." A few talked about misdiagnosis when describing their experiences. Some family members noted difficulties being included in the care of their family member, often relating to privacy barriers. These depersonalized approaches led to a lack of trust with service providers in the existing system.

"Like there's no empathy or compassion in the public system. You are just a number."

Pre- Experience Survey Finding

50% (n=7) of *clients* (individuals and family members) said prior to HH they always or almost always felt comfortable sharing personal experiences honestly and fully with past providers; 14% said usually; 21% said sometimes, and; 14% almost never

Impact on quality of life

Some respondents discussed how the wrong care, untimely care, or no care at all led to poor outcomes and resultingly a lower quality of life. Some of the undesired outcomes described were misdiagnosis, relapses, hospital readmissions and losing hope that they would find help for themselves or their loved ones. A few respondents talked about how these poor outcomes negatively impacted their employment, family relations, or overall quality of life. One family member shared that caring for her loved one is affecting her employment:

"And I think it's just the weight of everything is taking a toll on me…. And right now, it's affecting my full-time job because I'm in survival mode right now, which is really challenging."

Pre-Experience Survey Finding

79% (n=11) of *clients* (individuals and family members) said they have **missed time (in the past year) from paid and unpaid work because of the consequences of their (or their loved ones') mental health challenges and/or addiction concerns.**

Person-centred care in HH

Individuals and family members described their HH experience as being more *person-centred.* Person-centred care is defined variably throughout the literature; one definition, however, describes person-centred care as: 1) affording people *dignity, respect, and compassion,* 2) offering *personalized* care, support, or treatment, 3) being *enabling* and, 4) offering *coordinated* care, support, and treatment (Collins, 2014).

Dignity, respect, and compassion

Unlike their previous experiences, respondents described feeling listened to by their HH provider, and feeling like "somebody actually cared." Having someone that cared also meant that clients felt comfortable, like they could trust the HH service providers and that they or their loved one were "in good hands."

"It was great. I felt really relaxed and I felt that finally somebody actually cared, you know, that they wanted to help me get out of this."

Post-Experience Survey Finding

77% (n=41) of *clients* (individuals and family members) said they always or almost always **felt comfortable sharing personal experiences honestly and fully with their HH providers**.

Personalized care

Clients experienced a more personalized approach to care than in their previous experiences. Some referenced HUM's comprehensive assessment (CA) as an example of personalized care. Those that talked about the CA described how it provided an opportunity to talk through issues they had never talked about before, which was helpful in developing rapport and trust with service providers. A few described the CA as a "starting point" for their care and how it was helpful. One person shared the example of how the perceived "pill pushing" in the existing system resulted in polypharmacy issues for her, and how the CA uncovered that polypharmacy. The HUM physician was then able to reduce the number of medications she was on and educate her about her medications.

"That's probably one of the keys aspects is the fact that they are listening to you, they are listening to what's going on in your life. There's a personalized feel to it, whereas in other programs it's very much textbook, you know, and this has a much greater effect."

Post-Experience Survey Finding

70% (n=7) of the *individuals* said the comprehensive assessment **'definitely' encouraged them to get care for their mental health and/or addiction concerns sooner rather than later**.

Enabling care

Enablement refers to the degree to which people feel supported to develop their own unique range of capabilities (as cited in Collins, 2014). Many participants discussed how HH was available to

them at no cost. Some explained how they would not have been able to participate if there was a cost. A few talked about how they had spent so much money on counseling for themselves or their family member that paying for additional support was not feasible. The fact that care was being provided without cost was appealing for individuals and family members.

"I jumped on it because it was funded and there was opportunity there, so for us that made it much more feasible to attend because it was funded."

Removing cost was an enabler to care, as was information sharing. Many participants discussed how HH took the time to explain things and share information with them in a way they could understand (i.e., addiction as a disease, the nature of medications), which was helpful to engaging people in their care.

Post-Experience Survey Finding

69% (n=35) of *clients* (individuals and family members) said HH care providers always or almost always **gave them all the information they needed to make decisions.**

75% (n=38) of clients said they always or almost always felt **confident in their ability to take care of their health.**

Some also talked about how HH gave them choice in which aspects of HH to participate in and supported them with their decision by checking in with them throughout.

"They allowed me to make my own decision with amazing support behind it."

Post- Experience Survey Finding

65% (n=34) of *clients* (individuals and family members) said HH care providers always or almost always involved them as much as they wanted in developing a care passport (n=6) or family treatment plan (n=28)

Coordinated care

Respondents discussed coordination of care in their interviews. Some respondents felt service providers were "on the same page" and gave examples of when they discussed something with one provider it was brought up by another provider at a later time. However, a few described disjointed communication or how "the ball got dropped."

"This not having to tell your story to everybody you talk to over again from square one. The fact that they, within the group of caregivers, communicate with each other and understand his health and his mental health is just – it's just huge. And there's such a need for that kind of care and it doesn't seem to exist anywhere else."

"That's the only complaint that I would have is just maybe a little bit disjointed through the process maybe with all of the people that are involved, and I found that it wasn't as seamless as it could be."

Post-Experience Survey Finding

74% (n=39) of *clients* (individuals and family members) said they were completely satisfied or very satisfied with their care coordination with HH.

Many discussed the multidisciplinary team of service providers and how they appreciated the holistic, team-based approach to care:

"I can say, because I have a network of people it's not, it's all in different directions like for instance I can go to [Anchor of Hope] for a different reason than I'm going to HUM, and I have my group where I talk to specific things to my groups."

However, the interviews revealed that some participants were not clear on HH's scope, its collaborating organizations and how they related to one another. Some understood that HH connected the collaborating organizations; however, family members in particular used HH and Cool Family Solutions interchangeably since that was the component of the program most family members were familiar with.

Satisfaction with Harmonized Health

Post- Experience Survey Finding

73% (n=38) of *clients* (individuals and family members) said they were completely or very satisfied with the **quality of care they received with HH.**

Many respondents discussed their satisfaction with HH and how it has made a positive impact on

their life. Some said it is the only care that has made a difference, while a few said it has saved their life.

"I wouldn't be where I am, I know I wouldn't. I wouldn't be seeing the successes I'm seeing right now, and I definitely wouldn't have been able to repair a lot of the issues within my family life."

Family members discussed how they were given "tools" and "coping strategies" to address challenging situations with their loved ones. In particular, family members talked about learning about themselves and learning to let go of guilt.

"I think it's provided us with a little bit more clarity and understanding and the tools that we need to be healthier."

Collaborating organizations & roles

Many participants discussed the *expertise of the HH collaborating organizations*. Family members in particular discussed Cool Family Solutions and the positive experience they had with the *family component of HH*.

Expertise of HH Collaborating Organizations

Respondents often talked about the service providers at HUM, AOH and CFS. Respondents used terms like "amazing," "outstanding," and "great bunch" to describe the professionals in these organizations. Some went on to describe the expertise of the service providers working in these organizations and how they had an elevated level of knowledge compared to what they had experienced before. Some talked about how some of the service providers "have gone through at least some type of addiction themselves" and how that is helpful because the care they provide is not solely based on "textbooks," but also informed by lived experience. This level of expertise helped to build trust and a feeling that the service providers cared, as discussed above.

"I feel like everyone in the team has invested a lot of time into actual research of the people or has gone through at least some type of addiction themselves be it behavioral or substance. And so yeah, I just didn't feel like someone was reading from a book, do you know what I mean? They knew because they've seen people get better."

Family Component of Harmonized Health

Post- Experience Survey Finding

68% (n=29) of *family members* said they were completely or very satisfied with the **quality of care they received with HH.**

As mentioned above, some family member's experience of Harmonized Health was limited to CFS. When family members talked about their experience with CFS they often mentioned the effectiveness of the program. In particular, many mentioned the effective structure of how the group program is run and the facilitator's approach. Respondents often talked about how the program equipped them with coping strategies and tools that they could apply in their life going forward.

"I'd say that's kind of what I did take away, is you can't fight every battle with these kids, you got to pick them, and you got to support them, and you got to know when to kind of walk away, and you got to set some boundaries."

Post- Experience Survey Finding

73% (n=30) of *family members* said they were always or almost always helped by an HH service provider to **feel confident about their ability to take of their own health.**

58% (n=25) of *family members* said they were extremely confident or very confident in their **ability to stick with the agreed upon goals and plans with their Family Care Plan.**

Some highlighted the welcome uniqueness of a program for caregivers.

"Yeah, because we've been through the ringer for over 10 years and the focus was always on the individual. And that's not to suggest the individual isn't being focused on now, but to step away and as caregivers I thought it was, all right, the realization was, OK, as caregivers, there's a lot of weight and pressure on you and you need tools to help relieve you of that pressure so you're better positioned to address any concerns that may come up."

One person mentioned her disappointment that she wasn't involved in the care of her loved one, but instead only offered the CFS program.

Coordinator role

Respondents discussed the referral and recruitment process. Most individuals said they were made aware of HH and referred to HH through a personal connection with the TUF founder who took on the Coordinator role; seven out of eight clients interviewed had a previous connection to TUF or were referred by a friend or family member with knowledge of TUF.

"There's so many people that need this help. And if it was more readily available to anyone, not just people who know [TUF founder] or people who have heard of it or those sorts of things...there's a greater need for it for sure."

Interviewees described an HH intake process that centered on informal but thorough conversations with the Coordinator (TUF founder). However, some respondents noted that they weren't sure what they were "getting into" at the beginning and described a need for more clarity on the various components of HH and how they fit together. Some said that information became clearer over time, but thought it was important to have that clarity at the beginning of their HH journey.

"That's the part that I kind of felt to be a little disjointed. So, I wasn't entirely sure what I was getting into until I got into it. I think there could be some improvements made in terms of describing everything."

When talking about the Coordinator role, some discussed how this person took on an advocacy role that they appreciated. That advocacy was described as having a person that listened, but also who proactively called and checked in on them. One person described an experience where they had a "really bad appointment." The Coordinator and another service provider followed up and promised to fix it, which was different from previous experiences where they felt nobody "stood up" for them.

"I know you don't know my situation, but it's kind of horrible. They're just, it's nice to have someone just following you and tracking you just to see if you're okay and what you need as you go."

What's next

Interviewees were asked to comment on what they think needs to happen next with HH. Many respondents thought more people should be aware of and have access to HH. Some respondents discussed the COVID-19 pandemic in their interviews and how the pandemic exacerbated their mental health issues. A few went on to speculate that the need for mental health supports is going to grow because of the pandemic and the negative impacts it has had on mental health and employment.

"I certainly hope that it gets funded again and that more people have the chance to go through it. It's been a really positive experience for me."

A few respondents gave suggestions for process improvements relating to communication at intake. A few mentioned a "one-pager" or a better laid out "welcome package" to describe the components and process. One family member described not knowing what "all these appointments" meant and wanted more information on the intended outcomes of the process. One family member suggested a family meeting at the beginning with their loved ones and the service providers to help involve the family member in their loved one's care. Others suggested a longer term to the program (i.e., more counseling sessions), a building where everyone is together, and more comprehensive programming that included art therapy and a nutrition component.

To what extent do clients have improved outcomes?

Individuals' Recovery

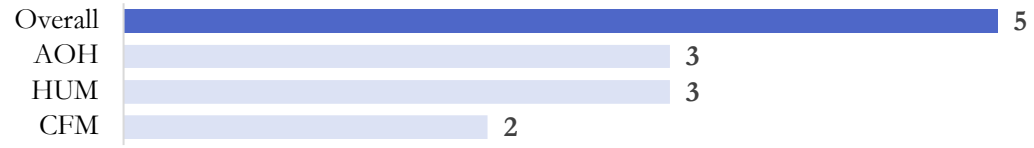
The Canadian Personal Recovery Outcome Measure (C-PROM) is a patient-reported outcome measure that has been designed and validated to assess recovery, which is the single most targeted outcome in the mental health literature (Barbic & Rennie, 2016). It is a 30-item questionnaire that is to be completed 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. For example, Barbic and Rennie's figure below shows that if an individual scores below 10, conversations and goal setting should target safety and hope. If scores are between 10 and 20, conversations and goal setting would be related to self-esteem and stress management. Scores above 20 indicate conversations and goal setting related to community, peace of mind and personal enjoyment.

Individuals' Perspectives of the Tool

When individuals were asked about the C-PROM tool on the post-appraisal survey (n=10) they described what they liked, disliked and how they will use it following completion of the HH project. Generally, people thought it was helpful to see their progress over time. A few thought that the number of questions and frequency that it was administered was too much. A few said they hadn't continued to use it or don't plan to use it, but the others said they would use it to check in on their recovery and to identify areas to work on.

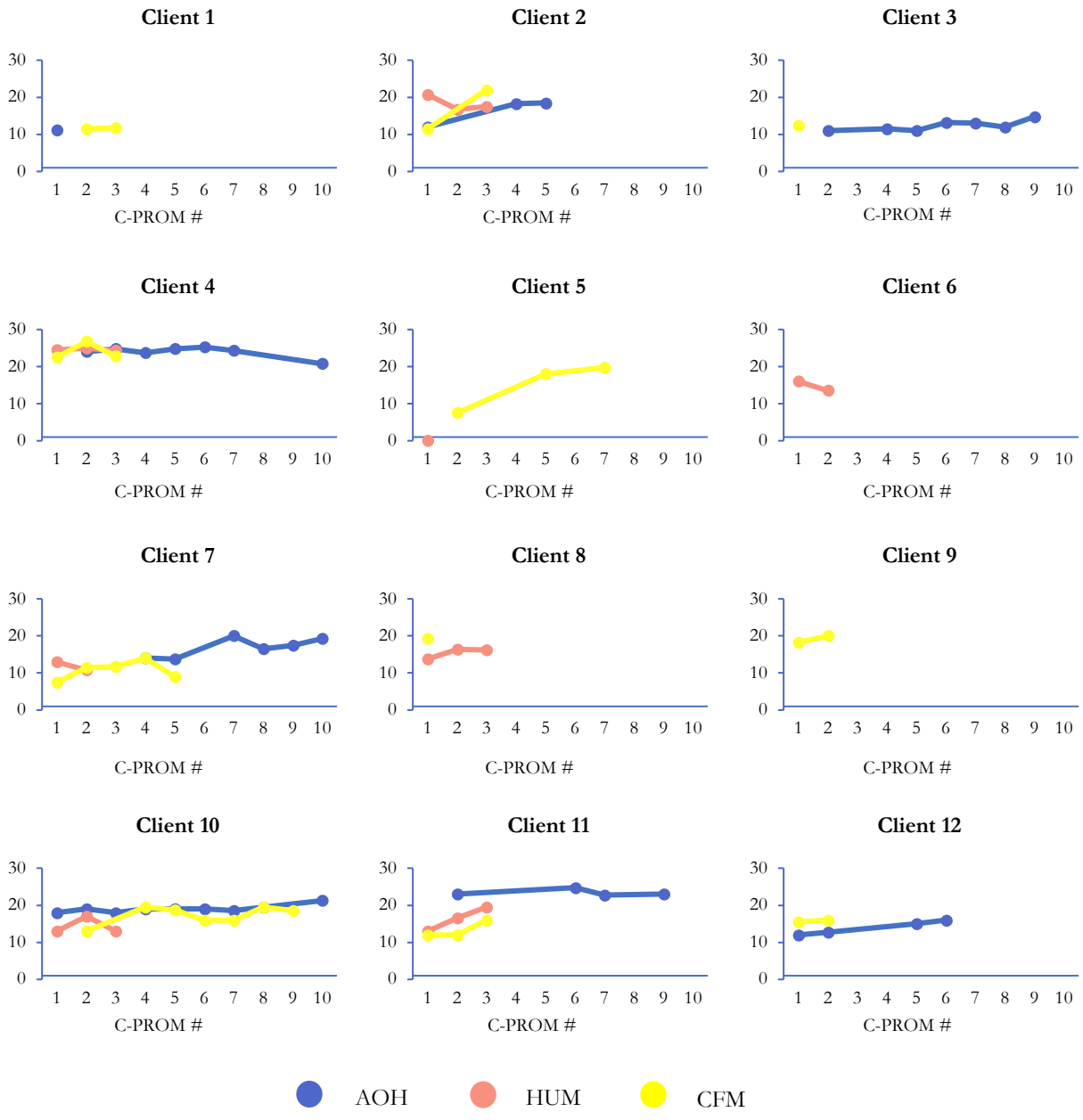
6 **average number of completed C-PROMs per individual** (for all client categories)

Anchor of Hope (AOH) completed more C-PROMs per individual than other collaborating organizations.



The following charts show each Category A client and the: a) C-PROM score, and; b) number of C-PROMs they completed (by type of visit)

For Category A clients, most C-PROM scores are between 10 – 20, which indicates goal setting should be targeted at self-esteem and stress management.



Family Members – Adult Resiliency

The family support program is delivered through CFS. The program is ten weeks long and 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 conversations 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 behaviour.

CFS uses *The Adult Resiliency: Social, Emotional Strengths Survey* to determine where people's strengths are upon entering the program and how those strengths have changed by the end of the 10 weeks. 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, 2018).

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 to 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.

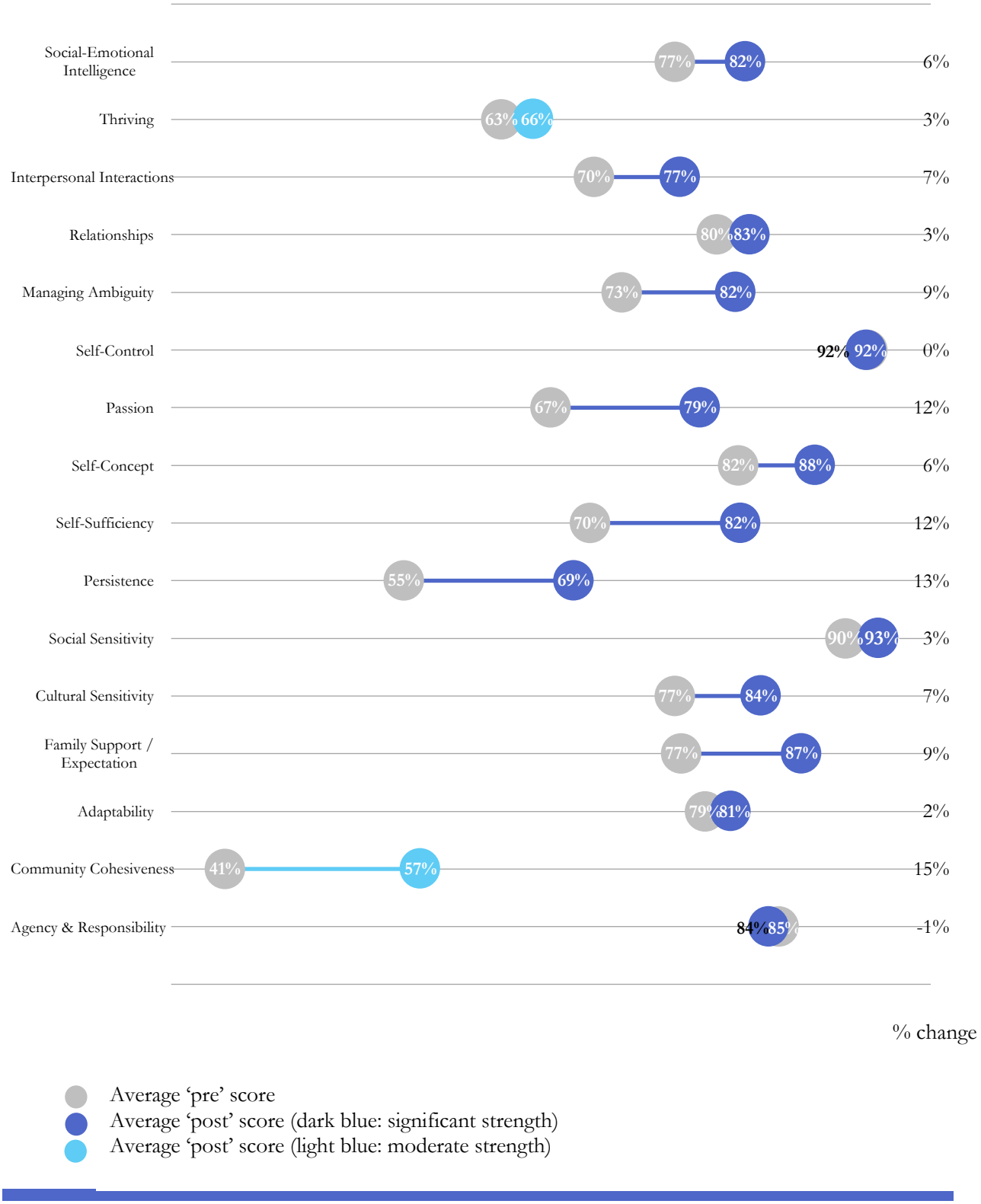
Significant challenge – suggests that the person is not aware of the strength, nor have they established it in their life.

Family Members' Perspectives of the Tool

When family members were asked about the Family Resiliency Assessment tool on the post-appraisal survey (n=40), they described what they liked, disliked and how they will use it post HH. Generally, people liked the tool and how it provided a thorough overview of their strengths and areas to work on. In addition, family members liked how it was a way to measure progress. Some liked that it is a tool for self-reflection and described learning about themselves and the "root of several issues." Others said the tool confirmed certain things for them. Some liked that it was a tool to cope and manage family conflict.

Many said there wasn't anything they didn't like about the tool. Those that did mention something said they found it confusing. A few noted that the self-reflection it brings about can be difficult. Most people said they would put the tool to use by reviewing it, using it to help focus what areas need work, measuring progress or sharing with family and friends.

The majority of family members' developmental strengths scores improved by the end of the 10-week program. The greatest improvement was seen in the persistence and community cohesiveness and persistence scores.



Client Stories

The following pages include two stories that were submitted by individuals and one family testimonial. The stories and testimonial are largely verbatim from what individuals submitted, with names removed.

Individual Story of Change #1

Asking for help can sometimes be one of the most difficult things to do. We live in a society that prides itself on self-reliance, keeping it all together (whatever `together' means), putting on a brave face, pervasive platitudes, quick fixes and instant gratification. None of this is useful when you're facing a mental health concern or crisis.

I have often asked for help or had it suggested to me. The first time I saw a counsellor was when I was 13 after my parents separated. I'm now 47. I have seen many counsellors over the years for a variety of reasons. They were either attached to schools (high school, university, and college), health services (like AHS), community resource centres (like North Rockyview Community Links in Airdrie), or workplace EFAPs (Employee Family Assistance Programs). Some counsellors were better than others and some methods of treatment stuck more than others.

I reached out to the Harmonized Health program in December 2020. I was experiencing what I considered to be a crisis; my husband and I were having the kind of arguments that I had never experienced before in our 18-year marriage. I have been a stay-at-home mom for 12 years and I was experiencing what I had never hoped to experience— the urge to leave — without the means to do so. And I needed care in a timely fashion to help bring me to a place of calm, so I didn't need to leave and disrupt my family's life and my own. I had been seeing a counsellor with Community Links earlier in the year but had not continued as I was feeling better. I had tried to re-establish connection with the counsellor I had been seeing there but her earliest appointment was going to be more than a month away.

I had contacted Kim Titus of the Thumbs Up Foundation in December 2020 and expressed my interest to participate in the Harmonized Health project. Covid-19 pandemic restrictions meant that my access to many of the social supports I relied on (like library programming or swimming lessons for my kids) were not available. My social and emotional health, like so many other people's, had declined. I thought that there was no better time than during a pandemic than to do a `deep dive' into the state of my mental health. I am glad I made this choice. Participating in the Harmonized Health project meant that I had not just one counsellor as I had in the past, but appointments with two doctors, a nurse, and a social worker to help get to the root of some of the issues I have been dealing with for years. A comprehensive assessment with the team at HUM (Health Upwardly Mobile) revealed some things about my brain type that explained the way I had been feeling for many years — not all the time — but an underlying sense of sadness and some anxiety that returns in my life from time to time. The team at HUM made suggestions for me to get back on my feet again, so to speak.

Not only did I have regular appointments with two of HUM's doctors, I was also set up with a counsellor who has been working with Harmonized Health and I have been having regular appointments with him on a virtual platform. He is the best counsellor I have seen before, and I have been in many counsellor's offices over the past 35 years. In addition to this, I also participated in weekly virtual meetings about family communication and learned valuable information which has helped me function better in my family life. And, I have been participating in weekly group therapy sessions.

Expressing my feelings has never been a strength for me and I feel like I am learning to do this in a safe, non-judgmental atmosphere.

I have benefitted greatly from being involved in the Harmonized Health Project. I can't say that any one part of it has been better or more valuable than the other; each piece, whether individual counselling or group therapy functions like a spoke on a bicycle wheel. Each spoke contributes greatly to the wheel's ability to provide a safe, smooth ride for the rider. Take out one spoke, and you might be able to still ride the bike, but you might not have the best ride either.

Harmonized Health has been a wonderful opportunity for me to learn more about myself and it has also been about community. When

people are facing mental health and addictions issues, they often feel like they are all alone in what they're going through. And they're not. Engaging with others with similar thought patterns and life concerns breaks down the problem of isolation that many people use as a solution to their problem, thus making it worse. I'm humbled by hearing about the life experiences of others and out of this, I have made new friendships.

I have benefitted from having access to a team of qualified, caring professionals who genuinely want to see me succeed and have been invested in my well-being right from the start. When dealing with mental health challenges, continuity of care is incredibly important, yet does not seem to be the standard that people receive. If I go to a hospital for a medical health care crisis, like a cancer diagnosis or a heart attack, I am likely to see many doctors and nurses and hopefully some of them will become my `regular doctors' for as long as it takes to resolve my medical concern. That care team knows me and they know my history. Imagine if we took the same approach to continuity of care with mental health concerns as we did with physical health? I imagine broken hearts, broken spirits and troubled minds might be given a greater chance at healing.

I'm grateful for the chance to have participated in the Harmonized Health project and I truly hope it is made available to many more Albertans. When the pandemic abates, there will be more people, especially people working in `front line' positions who would benefit from a multi-faceted approach to dealing with their mental health concerns. Let's set them up for success in the future and make a healthy `me' to a healthy `we.'

Individual Story of Change #2

Prior to Harmonized Health, I was feeling like I've lived two different selves my entire life. I was at times successful and doing better than most days/months, but even in those times addiction has always been lurking and as time went by it got easier for me to just let my addiction(s) take over and my road to recovery kept getting harder and harder. I was definitely concerned for my future as I was spinning out of control once again.

I have spent most of the first half of my life doing just that, spinning out of control and that seemed to be my normal and almost a routine. I was sick of it and I for the first time went alone to seek help. When I say alone, I mean previously I would end up getting help because it was noticed and was suggested by a friend or family member, or a big blowout happened such as suicidal attempts. I have been to treatments centers and hospitals, and they have all been great for me and I certainly learned things throughout those times, but after I would leave, I would feel good again for a time and it would creep back up on me and sometimes without me even noticing. On occasions it was instant because I was not understanding the urges and the feelings I was having.

When I was fortunate enough to land in Care First Medical Centre, I basically asked [the physician] to please diagnose me with something because I cannot do the second part of life like this even if I was free of substance abuse. I still felt wrong and not right. Out of what I can only describe as pure chance and through him, I was connected to Harmonized Health.

The opportunity was presented to me, and the offer was on the table for me to grab. I did grab it and for some reason the stars were lining up was it because I knew I was doing it for me. I can just say that Harmonized Health has given me a true gift and the information/knowledge I learned through HUM, IOP (Intensive Outpatient Program) and AOH was and continues to be absolutely incredible. I learned so much within a three-week period through the HUM team that it gave me an understanding of my past behavior, such as I didn't understand why it never stopped and why I would stop one thing only to pick up something else. It was explained to me as being the "wack a mole" effect, my addiction(s) were not in particular things, it is one thing that walks with me I need to stay ahead of it, and they gave me insight about myself that I feel I should have known. I now understand that addiction is a part of me, but it is most certainly and most definitely not all of me.

I was taught to run away when things where uncomfortable to avoid uncomfortable conversations and to definitely avoid uncomfortable feelings. I now am teaching myself to embrace uncomfortableness in order to grow rather than feeding them with multiple substances along my way through life. I have a buildup of metaphorical lumps in my throat that won't go away quite yet because I've never let them out, rather I have blocked them inside of me till now. With Harmonized Health I have a network of professionals as well as others like myself where I can dump my lumps so to speak in a safe and healthy environment.

Harmonized Health has impacted me in so many ways, but also so many loved ones.

Several people in my life have seen the positive impact that Harmonized Health and HUM have had on me that it actually motivated them to seek their own recovery. That is how powerful these programs are.

My future is looking very different from my past and I am now enrolled into an Addiction and Community Health Professional Program that will be starting in August of 2021. I want to be dedicated to my recovery as it comes first, and I would truly cherish and love someday to share this gift and provide opportunity to those who are spinning out of control themselves. I've robbed myself and my loved ones of many years through the first 1/2 of my life and thanks to Harmonized Health I will not rob them or myself of the second half of my life. My plan is to fit my life into my recovery and have as many uncomfortable moments as I possibly can!

A Family Member's Testimonial

My experience with Cool Family solutions has been eye opening on so many levels.

I started out looking for a volunteering opportunity as I was determined to help others through the all-encompassing challenges that mental health issues bring to a family. I have supported both my son and my husband through anxiety related issues and PTSD while we also struggled to keep the other parts of our lives together.

What I discovered is that there are so many more people than I realized that need help, but by taking the 10-week program myself, initially so that I could see first-hand how it works and the benefit to others, and ultimately be a better volunteer and support, I discovered that I was on the brink of slipping into a further setback myself.

The self-awareness I have gained, in being better able to see the warning signs and beginning of my *own* issues caused by self-neglect as I was hyper-focused on my family, was invaluable. In stressful situations its natural to hyper-focus and look for quick solutions, but what I learned is that our focus is usually based on fear and a desperation to regain and keep control of our lives and protect our loved ones. But I learned that this kind of focus often means we end up adding to any issues we're facing, or in my case, spreading yourself too thin and therefore not giving your best to the very people who need you and your best the most.

The structure of the program sees honest conversations between strangers (at first) and provides an honest but supportive perspective of how your own situation, as well as the "how and why" of your management of it is affecting others. The approach is so beneficial and it kindly and gently creates a self-acknowledging insight that lets you see the *reasons* for your own responses and therefore you are more able to genuinely consider alternate approaches without feeling inadequate or guilty. It's never about, "you're doing it wrong", it's about doing it *differently* because you are helped to see the viewpoints and realities of the loved ones you're trying to help. This means that you are sincerely and EFFECTIVELY able to help them through constructive understanding, instead of panicked "fixing" that's founded in fear and stress.

Mona's selflessness and example of the benefits that her own self-awareness and acceptance has created in her life is the basis for the program that she has worked for years to develop. I am grateful for the opportunity and the lessons that I take away every week that I can quickly implement with immediate results. For example, I had been struggling recently with stress partially due to my son's sudden change in study direction right before he was due to apply for a teaching program. I thought I was being supportive and encouraging in helping him to decide on a different program, but I learned *my* fear was coming through and making him feel guilty and pressured because he became aware of how his uncertainty might impact *my* plans over the next year. I realized that my current and daily stresses should have ZERO impact on the decisions he needs to make for himself and his own future. Although unintentionally, I had been adding my stresses to his, making his decision process more difficult.

With this new insight, I approached the next discussion about university from a completely different angle and simply questioned his plans and intentions that he has for himself, rather than making "suggestions" which was only adding to the pressure and causing distraction. The result? He felt relieved, focused, and confident enough to apply to two programs of interest at a local university open house two days later.

Mona's program shows us that despite our good and best intentions, we sometimes let our fears and panic cloud our thinking, which comes through in our interactions with the very people we're trying to help, creating a "two steps forward, one step back" scenario. She helps you genuinely work together towards whatever goals your family has, in order to resolve any issues you're facing. It creates self-awareness that then allows you to finally and effectively help the people you love.

Service Provider Perspectives

The following data was collected by interviews with seven service providers, representing each of the four collaborating organizations, and three operations team members. For the purpose of identifying the HH Pilot Project outcomes, operation team members were interviewed regarding their service provision responsibilities, rather than their project management or backbone roles. Refer to the appendix for more details related to the interview methods.

The data below represents the overall themes from these interviews. The service provider and operations team interviews were analyzed together. Given there were more service providers the themes that emerged likely more heavily represent the service providers perspectives. For further discussion of this data refer to the Key Findings section.

Harmonized Health is Different from Traditional Mental Health Models.

Participants frequently highlighted the shared vision:

"I think the vision is building a better mental health care service and a healthier community, which, you know, I think we're all on board with that."

Participants were likeminded, envisioning a service delivery partnership that eased clients' traditional burden of "navigating our broken system." Participants emphasized the uniqueness of HH, highlighting that this "approach is more personalized" than traditional mental health models, which allows for the "degree of flexibility and honesty" needed to "approach people in a real manner." This personalized approach creates that "caring, compassionate relationship" that attends to the whole person holistically, turning from the traditional model of acuity and fragmented short visits to chronicity and long-term engagement in the process of recovery.

Participants reflected on the current system's acute approach to mental health, acknowledging its contribution of being "good in crisis," but simultaneously identifying that the "current system does not work for mental health and addiction" in a broader sense. Ultimately, participants had a shared vision of "building a better mental health care service and healthier community," which required a "shift in paradigm and perspective" toward "more chronic long-term support as opposed to episodic care."

Participants described a second necessary shift toward a disease-based model for treating mental health and addiction. This shift meant abandoning the psychiatric language of behavioural disorders and their medication treatments, in favour of addiction and mental health, or "brain-based" language. Adopting the disease-based model was seen as radically different from the traditional system, where clients are seen as "bad and not sick." Once clients were appropriately identified as sick, the opportunities for treatment could be explored more holistically. Some noted that this distinction was transformational for clients, relaying stories of their "relief" at coming "out from under" the label of being "bad."

Collaborating Organizations Operate Differently

While participants commented on the importance of these paradigm shifts as the foundation for their services, they also identified several unique aspects of services linked together through HH. Service providers saw HH as the linking organization, facilitating relationships and initiating collaborative infrastructure. First, participants commented on the effectiveness of the individual collaborating organizations linked under the HH umbrella. The counselling, family and HUM programs were recognized as "great based on outcomes" and distinct from the "lots and lots and lots of programs" in the community.

Participants commented on the "huge accountability part" to the way services are delivered with HH, which were considered core to their effectiveness.

They also address the "family piece [which] has always been left out." Some participants were clear in differentiating the specific HH collaborative organizations from other community-based services. The content and approach of these programs were unique for them and a key reason for the results HH was able to achieve with clients. One service provider commented: "I don't believe in using what exists in the community… there are lots and lots and lots of programs, lots of them and less than 5% are effective." This provider saw a need for the HH service delivery organizations to train other providers to achieve the results observed in HH because "the reason why this works is [that] the [service providers] are different." Linking these effective programs and building connecting infrastructure will enable improved continuity of care. One provider noted:

"I think what's novel is we're trying to come at this where every discipline is represented. It is a one-stop shop. The patient is not expected to govern our broken system."

The Coordinator Role is Essential

Participants were largely unified in seeing the importance of a coordination role as part of HH. This Coordinator role was described as "directing traffic" or providing the "roadmap." It was "vital," "the glue we don't have in our current system" meant to ensure that clients were "not getting lost in that process" of care. This role included a broad array of activities, including "developing those early relationships," advocacy, and being the connection between the clinical pieces and community pieces of HH. Ultimately, the "role is incredibly invaluable."

For the HH Pilot Project, the Coordinator role took on a variety of responsibilities (described earlier). While a combined role offered HH the ability to have a single person to ensure that HH clients do not "just fall through the cracks" and a person who continues to "tie in all the service providers" while they "learn how to connect" their traditionally siloed practices, several participants pointed out the weakness or vulnerabilities of having one person in this role. Providers commented that it is "too much to put on a single person" and bred a "dependence on one person." Additionally, this highly centralized method, at times, interfered with logistics and efficiency and contributed to a lack of consensus in how the vision could be reached. One provider commented, "I think there was a disconnect between what the vision was [and] what was possible from a practical side of things." Some providers felt that this centralized role was too heavily involved in clinical decisions and that additional boundaries were needed to clearly delineate the scope of the Coordinator role and that of the clinicians. Providers were concerned about the sustainability of this role, how to better integrate the role within the existing system, with some providers expressing that "coordination has to be amongst the professionals" to a greater extent. Ultimately, this role was seen as vital and at risk in its current form.

Broadly, participants felt the intake responsibilities of this role should be "open to the broader community", rather than the current "one funnel point" of intake. Participants differed in whether they felt intake should be located within the primary care clinic or in a more lay person setting. Some saw the value and perhaps additional comfort potential clients might experience in asking for help from a lay person, rather than a professional. One person focused on the importance of this person having a 'lived experience.' Several participants agreed that the "intake, glue role" needed the following characteristics:

- "Somebody who is very capable of *establishing healthy boundaries."* Participants discussed the high likelihood of burnout without healthy boundaries in this role. Boundaries included: not being the emergency contact for clients, never giving "out your personal cellphone," and not being constantly available. Without these boundaries, providers worried about the sustainability of the role, being overly emotionally involved in clients lives and becoming too heavily involved in their journey. Providers were clear that the "friend quality" needed to be maintained, while introducing "very clear boundaries."

- "Somebody who is capable of *working some different shifts"* to ensure the program remains accessible. For some providers, this meant that "several engaged people" were needed, rather than one individual. This "outreach team" was also seen as the way to opening intake to the broader community, rather than having intake be through "one funnel point."

- "Somebody who *understands the brain health*… [and] has that basic knowledge to impart."

- "Somebody who *knows about systems and programs."* Providers struggled with ensuring that the Coordinator role had sufficient "understanding of clinical systems" to "be realistic when they tell the patient about what's available" in terms of appointments and speed of follow-up. This was particularly important for clinicians who operated in the more traditional system and needed "to make it work within the system too."

- Somebody who *knows "how to triage."* Some providers highlighted the need for the coordinator/intake role to have "some sort of experience and training" to facilitate appropriate triage.

Community Peer Support is a Needed Component

HH continues to develop the community peer support part of the program and the peer navigation component that falls within it. Peer navigation, while in its infancy, was seen as an opportunity for development by several participants. One participant reflected that peer connections are often missing in existing programs and that peer connections offer an opportunity for those with lived experience to share their knowledge and walk alongside or "do life with" clients. One provider commented on the "opportunity to really develop that role and make it much more robust… like a case management role, but a non-clinical case management."

Cost Considerations

The lack of dedicated administrative resources made it challenging for providers to attend to all the new processes and procedures of HH. Some service providers felt they were volunteering their time to conduct the additional extra duties (i.e., tracking monitoring and evaluation data for clients), which were outlined as part of the HH Pilot Project, but were not compensated for. The financial challenges associated with attracting, training, and retaining staff were noted. Additionally, the HH staff who took on the roles of coordination and peer support, who were seen as integral to HH for several providers, relied on the funding of their position. One service provider commented that without that funding, "I don't know how you would do that" or maintain those necessary functions. A few service providers noted that the only way to continue HH without continued funding would be to charge patients directly. However, this was a contentious issue for participants who saw the financial burden of accessing care as "a barrier for many people to seek help" and "unfair."

Lack of funds was also highlighted as a barrier to optimal model design, development, and adoption. For example, providers frequently highlighted the issues with HH data collection processes in light of the absence of a comprehensive and shared electronic medical record (EMR). While the specific issues related to a shared EMR will be discussed further below, one participant suggested that a lack of funding was one reason why the project did not provide an integrated EMR.

Collaboration and Barriers to Integration

One of the primary goals of HH was to integrate services: developing relationships as well as clear, consistent communication across the spectrum of community-based service providers. This goal required acknowledging the current "very siloed" system in terms of approach to treatment and record systems. In bringing all these aspects together HH participants highlighted that "when we put all the services together, people are getting well." Creating feedback loops between providers would remove the "pure blind faith" of traditional patient referrals processes and support the development of more effective treatment plans.

Fostering relationships and building infrastructure to facilitate collaboration was an integral component of HH. Participants who were a part

of the initial establishment of HH spoke of the importance of relationships in developing this collaboration. Participants reflected that "everything is about the relationships" and that "it comes down to connection at the end of the day." Without these relationships, the project would have struggled to find both providers and patients. Connecting to other service providers and the associated training from experts, such as HUM, was noted as producing "a lot of positive things." Maintaining these relationships was viewed as necessary for continued HH functioning.

Because many of these relationships developed personally, some providers commented on the struggle to move from the personal relationship to clearly defined roles. "Having defined roles is critical" to effective collaboration, yet some providers felt that rushing through the program development phase left them with a limited understanding of the "other components" of HH. A limited understanding of each other's roles and programs had an effect on inter-provider communication and collaboration. Several participants commented on the improvements in communication throughout the course of the pilot and how the communication "has improved" and is "getting better." However, "the biggest breakdowns" have remained in communication. "Trying to tear down silos, when you have that many service providers" is difficult and returning to the familiar siloed approach out of habit was a common experience. Since most providers also worked within the traditional health system, navigating that constant "shift in perspective" was challenging. Several participants noted that communication pathways needed to be easier and simpler in order to help combat defaulting to "operate in our silos."

For many providers, increasing the ease of communication and collaboration was embedded in building an integrated EMR, which would facilitate provider interaction and updating more seamlessly. Some participants noted that introducing the instant messaging capability has positively affected collaboration between providers, while noting that more could be done to improve collaboration.

Several providers distinguished between HH's current practices of facilitating collaboration from service integration. While providers saw their interactions with one another increasing, the fact that many did not understand each other's roles, and found it cumbersome to access each other's notes or consult on care plans meant that they were, at best, collaborating rather than integrating. When considering what would need to change in order to reach the level of "integrated services," one participant reflected, "honestly, to make the whole thing simple and like seamless would be [to have] a one-stop shop; one facility with every single service provider under one roof. That's how you get the full communication" and integration. The importance of co-location of service delivery was echoed by a number of participants. Others felt that although a shared physical location "helps with integration" a sufficiently integrated EMR could mitigate the challenges associated with being physically dispersed.

HH service providers identified a disjointed and duplicated data system as one of the contributors to communication issues. The HH operations team explored a variety of data management options, and a decision was made to proceed with AirTable and Nula, in addition to any data systems (i.e., EMR) already used by service providers. Some providers expressed their concern about this approach from the beginning, highlighting that it would have been more appropriate to first develop an integrated and shared EMR, then recruit and train collaborating organizations as needed, and finally, engage patients. Consequently, some providers felt that HH was "developed backwards." Providers highlighted that the two HH data systems were "very repetitive," "not very helpful" and that "finding stuff is very hard in it." Given its duplication with their own EMR, some clinicians opted out of using the additional systems; their clinical responsibilities needed to be prioritized over navigating additional data systems. At times, clinicians were concerned that the volume of data collected – and the frequency of collection – got in the way of clinical care and were uncertain "how much value any of those things provide." The volume of data made it "really hard to just piece together all that information" and realize any benefit from it in developing treatment plans. According to one

provider, "all these pieces… that don't interact with each other… it just becomes too much."

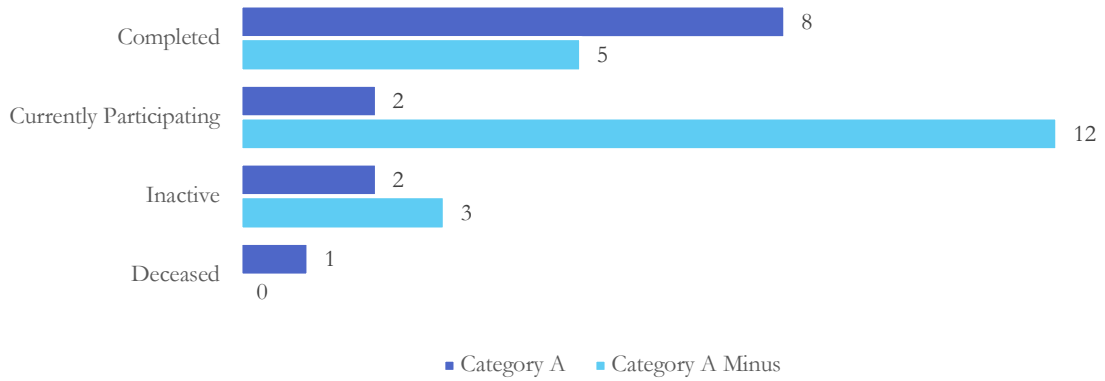
Having these duplicate and non-integrated data systems was a substantial barrier to integration for clinicians. For example, providers found it cumbersome to share clinical notes and observations on clients' progress; therefore, this aspect of integration rarely occurred. Additionally, a number of functions that could be automated within an integrated EMR (e.g., notifications to schedule next appointments, reminders if patients 'next step' hadn't been scheduled, etc.) all needed to be done manually. It was difficult to find the time or even to remember to do these additional tasks as they were not integrated into providers' existing workflows. The overwhelming nature of the documentation coupled with its lack of perceived usefulness led some clinicians to share that they do not use the HH systems, didn't even know how to log into them, or paid support staff to handle reporting into these data systems.

Typically, integrated EMRs also have the capability of instant messaging between providers. More recently, HH has introduced another system (i.e., Microsoft Teams) to allow for this function. Previously, this functionality was not available, making communication between providers relatively rare. For providers, having "an integrated EMR [is] absolutely mandatory." As providers considered how to improve the current collaboration, a shared EMR was identified as pivotal, specifically one that had been designed with the clinical team. Without the shared EMR, clinicians felt integration was not possible.

Emergent Findings

The majority of findings contained in this report were gathered from April – June 2021 and compiled in this report in July. From July to August additional findings have been provided by the HH operations team.

Current Status of HH Individuals (as of August 13, 2021)



Harmonized Health Evolution

The collaborating partners have evolved since the start of the HH Pilot Project:

Anchor of Hope is looking to recruit and train another counsellor to meet the rising demand.

Cool Family Solutions has also hired additional staff. She has also held mentoring sessions and filmed some sessions to demonstrate how sessions are structured and facilitated.

Care First Medical has one physician trained through HH and has hired a social worker. CareFirst Medical is also looking at how it can expand its EMR to be accessible to other service providers.

Health Upwardly Mobile is no longer participating as a collaborating organization under the HH umbrella. The primary reason HUM is choosing to no longer participate is because the comprehensive assessment – a process developed by HUM – is intended to determine what care people need; however, HUM felt that the comprehensive assessment recommendations were not being used to guide care. Instead, HUM felt the Coordinator (TUF founder) was directing people to other HH collaborating organizations without regard for the comprehensive assessment recommendations. Going forward, HUM intends to continue providing comprehensive assessments to any client who wants it done; they will also continue to provide training to service providers as they did prior to participating in the HH Pilot Project.

Community Supports – Originally there were two Peer Navigators (volunteer positions); six additional Peer Navigators have been added.

Key Findings

Key Finding #1 – Harmonized Health offers a more person-centred model of care.

Clients, service providers and the operations team discussed how HH is different from traditional mental health and addiction models. Client and service providers valued the HH model because it provides an approach that focuses more on long term, community-based support as opposed to short, episodic, inpatient care that is commonly experienced. In addition, clients, service providers and the operations team highlighted how HH uses brain-based language and a disease-based model for treating mental health and addiction that is different from traditional mental health models, but important to reducing stigma, building trust with service providers and engaging people in their care.

Stakeholder groups felt that HH offered a more 'personalized' or 'person-centred' approach to care than traditional mental health models. Client journey data showed that each person's journey through HH differed.

Clients described feeling listened to and a greater sense of trust with service providers in their HH journey than they had experienced in the past. Many clients described more satisfaction and success with their HH journey than they had experienced in the past.

Key Finding #2 – Harmonized Health's collaborating organizations and their service providers operate differently.

Clients, service providers and the operations team thought the approach and content of the services the collaborating organizations offered were different from the existing system. Clients felt that HH service providers had an elevated level of knowledge and more experiential knowledge from what they had experienced before. Service providers and the operations team thought the collaborating organizations offered more effective programs that are based on different content and approaches than other community based mental health and addiction programs.

The family program offered by Cool Family Solutions was described by clients, service providers and the operations team as a unique aspect. Family members described how most traditional services are focused on the individuals dealing with mental health and/or addiction struggles and how family members have fewer resources to help them cope. Family members felt the Cool Family Solutions program was effective and gave them the tools and resources they need for improved resiliency. In addition to Cool Family Solutions, service providers thought the community peer support element of HH was important because it brings in the lived experience perspective.

Key Finding #3 – Integrated care is important but was not achieved.

Individuals, service providers and the operations team recognized the traditionally siloed approach to care and the need for a more integrated approach. Individuals who participated in HH liked the holistic, team-based approach to care; they liked having different avenues of support for their recovery. While some individuals described feeling like their care was coordinated between the different organizations, others described a disjointed process that requires clearer communication.

Service providers explained that while there may have been a common vision for integration, there was a disconnect between the vision and how the various HH elements were operationalized. The lack of clarity of

direction or "operating model" was challenging for several service providers. Service providers spoke of the need for defined roles for there to be effective collaboration. Some providers felt that the one-year pilot project timeline resulted in rushing through the program development phase left them with a limited understanding of each other's roles and the "other components" of HH, which had a negative effect on inter-provider communication and collaboration. Service providers felt that HH was helping to facilitate collaboration between the collaborating organizations, but that true integration was not achieved and could not be achieved without some fundamental operational and systemic changes.

Key Finding #4 – A Coordinator role is important but requires further clarity and development.

Service providers and the operations team were largely unified in seeing the importance of a coordination role as part of HH. For clients, they appreciated how the Coordinator proactively called and checked in on them, but also advocated for them. However, service providers expressed concern for how the role was operationalized and did not believe it could or should be sustained in its current form. Instead, they thought these responsibilities should be transitioned to someone who is not linked to TUF and has a) knowledge and understanding of the health system, b) expertise and training in triage, c) the ability to state and maintain healthy boundaries, and d) the ability to work different shifts. Refer to Coordinator Role section for background and rationale as to why the TUF founder acted in this role for the purposes of the pilot project.

Key Finding #5 – An integrated system is needed to support quality improvement, evaluation and integrated client care.

Having non-integrated EMRs and additional data capture systems (Nula and AirTable) was a substantial barrier to integration for service providers. Some service providers thought there needed to be an integrated EMR in place before HH even started. For providers, having to enter information into various data systems was duplicative, overwhelming, and unnecessary. Some clinicians opted out of using the additional systems; their clinical responsibilities needed to be prioritized over navigating additional data systems.

A non-integrated EMR as a barrier to integration is not unique to this project. According to Carbone et al. while EMR adoption is shown to lead to improved interprofessional integration, an important driver of EMR adoption is its potential for interoperability among providers and settings. While it is understandable that service providers would have liked an integrated EMR prior to beginning the project, the cost would have been prohibitive for a pilot project. As such, the HH operations team tried to put into place an alternate, cost-effective way to capture client data. From a service provider perspective, they felt the amount of data being captured was overwhelming and unnecessary. The operations team felt it was important to be able to capture and monitor clients over the course of the project for ongoing quality improvement and evaluation purposes. In addition, clients expressed liking how the tools captured their recovery and resiliency journey.

Key Finding #6 – Cost is a barrier to entry.

One of the underlying assumptions of the HH Pilot Project model was that cost is a barrier to entry. Clients, service providers and operations team members validated this assumption in the evaluation by indicating that clients could not afford HH care or would be less likely to seek and sustain care if they needed to fund it on their own. To mitigate this barrier, client care was funded for 12 clients (Category A) as part of the pilot project. During the pilot project there was additional demand for care and 21 Category A Minus clients were provided care; these costs were/are funded by TUF. After removing operational costs, the estimated "all in" average HH cost per person was approximately $2100.

Limitations

The following limitations should be considered when interpreting the findings in this report:

Client Inclusion – While HH has served 121 individuals with various aspects of its model, only 12 individuals were funded for the HH Pilot Project (i.e., Category A clients). At the writing of this report, some of those individuals had not yet completed HH (n=2); two individuals are inactive, and one has passed away. As a result, ten people completed post appraisal experience surveys.

The TUF founder acted in the Coordinator role. While putting the TUF founder in this role may have been beneficial for pilot project recruitment purposes, it is important to consider how clients' connection to TUF could positively bias the findings.

Clarity of Harmonized Health – The findings described how some clients found they needed more clarity at the beginning of HH. For some interviewees it was not clear if people were attributing their comments to HH as a whole or to the individual collaborating organizations they interacted with. In particular, family members often spoke solely about their experience with CFS since many had less knowledge of the other aspects of HH.

Service provider interview analysis – The evaluation process of interviewing and analysis the service provider and operational team members together could have contributed to a combining of perspectives. The Project Leads were interviewed for the interim report where HH history and model implementation and adoption were the focus. For final report, the focus was on service providers experience and the project outcomes from their perspective. Since some of the operational team members also provide services within the project framework, they were included in the final report interviews. Given that these individuals had overlapping roles, it was, at times, difficult to construct their service provision narrative, rather than their operational process narrative.

Summary

Transforming how mental health and addiction care is delivered is complex. Complexity means there is high uncertainty about what works, disagreement even about the nature of a problem, no right answers, and nonlinear interactions within a dynamic system (Patton, 2010). Creating a setting that is conductive to innovation means having strategies that set a clear and firm direction, but are flexible, adaptable, and responsive to changing conditions and contexts and that allow for the emergence of a continually improving model (Antwi and Kale, 2014).

The findings highlight that the HH Pilot Project offered a more person-centred approach to care than clients had experienced in the past. When discussing person-centred care, clients spoke of how HH provided care that: a) offered them more dignity, respect, and compassion than their previous experiences, b) was personalized, c) was enabling and from their perspective mostly coordinated.

Since this was a pilot project, there is a relatively small number of clients to base these findings on. In addition, two individuals have not yet completed their HH journey. However, both qualitative (interview data) and quantitative (survey data) data indicate clients were more satisfied with the quality of care they received through HH than prior to HH. In addition, the resiliency data collected from family members indicates that family members are experiencing positive improvements following the 10-week family program. C-PROM data was inconsistently administered and does not show any clear trends at this moment.

While HH Pilot Project did deliver on the "people first" approach it intended, there is a need to further develop the HH model to achieve the seamless, integrated care it intended. Integration was hindered by the need for more refined program design and operational processes, but also by health system barriers. As HH continues to develop, the following recommendations should be considered.

Recommendations

RECOMMENDATION 1: CONTINUE TO OFFER A PERSON-CENTRED MODEL, WHICH IS ADAPTABLE TO CLIENT NEEDS, WHILE FORMALIZING SOME ASPECTS OF THE HH CLIENT CARE PATHWAY(S). Work with service providers to refine and communicate the HH journey and processes for clients, while maintaining the personalized care clients value.

Rationale: *Client journey data showed that each person's journey through HH differed. While clients and service providers valued the personalized nature of HH care, it also meant that the HH journey and processes were sometimes unclear. Reviewing and revising the care pathways and how those are communicated is one way to clarify the HH journey. It will be important to balance the standardization of those pathways, with the personalized approach to care that is valued by clients.*

[Key Finding: 1]

RECOMMENDATION 2: SEEK OUT EXPERTISE TO HELP PROVIDE LEADERSHIP AND COACHING ON HEALTHCARE CHANGE MANAGEMENT. As part of that change management:

- Identify and develop a governance structure that includes a backbone organization. Continue to work with collaborating organizations and other mental health providers to update the governance structure as the HH network evolves over time.
- Work with collaborating organizations to develop a program design OR work with collaborating organizations to develop an environment and expectations that are conducive to innovation (i.e., emergent change and a continually adapting model).
- Consider how a mentoring program can help support the program design.

Rationale*: To some extent, HH was able to facilitate collaboration between the organizations, but not the full integration it had intended. Effective change management strategies that address the challenges experienced by service providers will be integral as HH seeks integration and transformational change. Currently, service providers are expressing a desire for planned change - a series of pre-planned steps (Antwi and Kale, 2014). Service providers pointed to the need for more operational clarity in terms of HH roles, programmatic design, and evolution. A need for more involvement of service providers in the program design and logistics was highlighted by several participants.*

Someone with expertise in systems change could help develop and refine how HH partners and collaborates with others. According to Antwi and Kale (2014), "in the context of Canadian healthcare, building commitment entails gaining support of the entire system, from patients, to doctors, to front-line nurses and hospital administrators, to personal support works and governmental officials. The presence of strong leadership and the ability to establish new forms of cooperation will play an important role in cultural transformation" (p.2).

HH has already explored the possibility of a mentoring program and its readiness to implement one. A mentoring program could be incorporated into program design to support training and overall culture change.

[Key Finding: 3,6]

RECOMMENDATION 3: IDENTIFY CORE VALUES THAT UNDERPIN HOW HH OPERATES.
Operationalize these core values through HH care principles and embed them in HH operations and systems (e.g., recruitment and onboarding of service providers, communications, mentoring and training programs).

***Rationale**: Clients, service providers and the operations team recognized the individual collaborating organizations as being positively different from the existing system, likely enabling the positive outcomes described above. While they identified an elevated level of knowledge and more effective content and approach, understanding the shared values and principles of care will be important in supporting integrated care.*

[Key Finding: 2]

RECOMMENDATION 4: IDENTIFY WHERE THE ROLE AND RESPONSIBILITIES OF THE COORDINATOR ROLE SHOULD BE TRANSITIONED TO AND THE TYPE OF TRAINING THAT PERSON(S) SHOULD RECEIVE.
Review the tasks and responsibilities of this role. Determine how to transition this role from the existing Project Lead (TUF founder) and which tasks should: a) be transitioned to another collaborating organization, or b) need to be recruited and hired for. Incorporate the core values and principles developed in above recommendation into the recruitment and hiring process.

***Rationale**: The Coordinator role was viewed as important by all stakeholders. In addition, HH data shows that this role takes on a variety of responsibilities. Yet, the role was contentious among service providers. Several participants agreed that it needs to be transitioned away from the TUF founder who acted in that role.*

[Key Finding: 4]

RECOMMENDATION 5: WORK WITH COLLABORATING ORGANIZATIONS TO ESTABLISH AGREED UPON SYSTEMS AND PROCESSES FOR CAPTURING CLIENT ACTIVITY AND OUTCOME DATA. Ideally the system would integrate with the EMRs and not require duplicate data entry. In addition, work with the collaborating organizations to streamline the client data that is collected so there is an agreed upon minimum dataset.

***Rationale**: Having non-integrated EMRs and additional data capture systems (Nula and AirTable) was a substantial barrier to integration for service providers. However, having systems and supports for monitoring clients' activity and outcomes is important for overall continuity and quality improvement and evaluation purposes.*

[Key Finding: 5]

RECOMMENDATION 6: DETERMINE HOW TO SECURE OR REALLOCATE FUNDING TO COVER THE OPERATIONAL AND CLIENT COSTS. Consider establishing mobilization of funding as a key accountability within the backbone role (see Recommendation #2).

***Rationale**: The HH Pilot Project funded operational and client costs.*

[Key Finding: 6]

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Appendix: 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 evaluation team analyst cleaned and analyzed the data in Excel. Descriptive analysis was done using Excel Pivot Tables and Pivot Charts.

Client stories of change and interviews

Individual story collection and interviews

In March 2021, the HH operations team informed individuals at a Thursday group session that the evaluation team was looking to collect client stories. The evaluation team prepared information sheets, including consent information and story prompts that were handed out by the HH team member. The six prompts were:

1. What motivated you to contact Harmonized Health?
2. How was reaching out to Harmonized Health different versus any prior experiences of reaching out?
3. What has the experience been like so far – what is different, what about it is working in particular for you?
4. How has Harmonized Health helped you and/or your family?
5. What advice would you give anyone contemplating reaching out?
6. What does the future look like for you?

At the following Thursday group session, an evaluation team member joined to explain the story collection process, the consent process, and to answer any other questions. From April to May 2021 individuals emailed their stories to an evaluation team member (n=4). Additionally, the Harmonized Health team reached out to clients to ask them to provide testimonials about their experience with Harmonized Health to provide to the Associate Minister of Health at the time, Jason Luan. These stories provided similar information to the stories of change. Three Hive asked Harmonized Health to reach out to the individuals who provided testimonials and ask the clients if they would consent to their testimonials being used in the evaluation. If individuals were interested, they provided their consent through a survey link and Harmonized Health provided Three Hive with their stories (n=4).

The evaluation team then reached out to the clients who submitted their stories to interview them about their stories and to fill in any missing details. Three Hive also invited all of the current clients who did not share their stories of change to participate in an interview with the evaluation team. The number of interviews conducted was determined by available resources.

In total, eight individuals consented to be interviewed (five story collection and interview follow-up interviews out of a total of eight individuals; three interviews without a story submission out of a total of 12 individuals). The interviews took place in April and May 2021 over the telephone. The interviews were 20 to

30 minutes in length. The interviews focused on exploring individuals' stories, including their experiences with HH, the care they received and to what extent it is or is not meeting their needs.

Interviews were audio-recorded for analysis purposes. Interviews were transcribed then analyzed using content analysis to identify emerging themes and ideas. A generalized inductive approach was used.

Family member story collection and virtual interviews

The Cool Family Solutions HH team member notified family participants about the opportunity to submit their story of change and/or participate in an interview with the evaluation team. Families could submit one story per family, but multiple family perspectives could be included in that story if they chose. Similarly, families could participate in one interview per family, but multiple family members could be present. Again, the evaluation team provided information sheets, including consent information and story prompts. Family members from the February and March cohorts were invited to provide their stories. No family members chose to provide written stories of change. Eight families participated in the interviews. Two interviews had two family members as part of the interview. The interviews took place in May and June 2021 over the telephone. The interviews were about 30 minutes in length. The interviews focused on exploring the family's journey through addressing mental health concerns for their loved one as well as their personal journeys navigating the healthcare system, including their experiences with HH.

Interviews were audio-recorded for analysis purposes. Interviews were transcribed then analyzed using an inductive approach. Thematic analysis was used to identify emerging codes and themes.

Service provider and operations team virtual interviews

Service providers were invited by the operations team to participate in a one-on-one semi-structured interview with an evaluation team member. Each of the organizations involved in providing services as a part of the HH Pilot Project were represented. An initial invitation was sent with a maximum of three reminders per service provider. For service providers who replied to the invitation consenting to be interviewed, an evaluation team member followed-up to schedule the virtual interview. Interviews occurred in April and May 2021 and occurred either over the telephone or via video conference.

A total of seven service providers and three operation team members were invited to participate in interviews. All agreed. Interview length ranged from 30 to 97 minutes (average: 55 minutes). Each interview explored the following areas of HH: 1) participant's involvement in the HH Pilot Project, 2) any relevant training they provided or received within the project, 3) communication, collaboration, and integration among service providers within the project context, 4) the effectiveness of HH from the service provider perspective, and 5) the sustainability and scalability of HH.

Interviews were audio-recorded for analysis purposes. Due to the nature of the interview discussion, the decision was made not to transcribe the interview in its entirety. Rather, the evaluation team member who undertook the service provider interview analysis, listened back to the audio multiple times. Field notes and analysis notes informed the identification several emerging ideas. A generalized inductive approach was used for the thematic analysis. A preliminary coding framework was developed, and then specific sections of the audio recording were transcribed to facilitate the refining of each thematic area. There were two data sources provided by HH that were cross-referenced and included in with the interview analysis: TalentC's Cultural Assessment Report to Management Team and a Two Stars and a Wish exercise. Both documents contain feedback and findings from service providers. Following the initial thematic analysis, some additional data was extracted to contextualize and provide further data for addressing three areas: the Coordinator role, the cost implications of HH, and barriers to adopting the HH model.

Experience Surveys

The individual and family experience surveys (baseline and post appraisal) were developed by the HH operations team and the previous evaluation consultant. The baseline survey asks about clients' health care experiences before starting HH. It also asks a few questions about their first contact with HH. The baseline surveys are 22 questions; the post appraisal surveys are 35 questions.

The surveys are completed in SurveyMonkey. The link to the individual baseline survey is sent following a welcome email from the HH Peer Coordinator and the post appraisal survey is sent the last week of the individual's participation in HH (completing last counseling session). The link to the family baseline survey is sent within the week prior to the start of the first family session and the post appraisal survey link would be sent after the last session was completed.

Six individuals and eight family members completed the baseline surveys. Six individuals had completed the post appraisal survey;43 family members had completed the post appraisal survey. 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.

Client Outcome Measures

The C-PROM and resiliency data were analyzed in Excel. The analysis used Pivot Tables, Charts, and formulas. Out of 50 individuals, 28 individuals had C-PROM scores recorded.

Ethics

All evaluation and quality improvement projects involve some degree of risk. To enhance the benefits and mitigate risks inherent in this project, we undertook an ARECCI Second Opinion Review. ARECCI helps leads of non-research projects to assess and develop strategies to minimize risk by providing a trained expert to provide an external perspective and make recommendations. ARECCI is not an approval-granting body. The Second Opinion Reviewer provided a review letter dated February 12, 2021.

A Second Opinion Reviewer met with Three Hive and HH Project Leads to discuss ethical issues such as consent and privacy and confidentiality of information subject to Alberta's Health Information Act and Personal Information Protection Act. The reviewer suggested making minor revisions to the HH consent forms to include additional information on how information collected will be used and how information collected will not affect the services they receive. In addition, it was suggested that the reading level on the consent be lowered to a grade six level. The reviewer also suggested if there is the intent to scale and spread, then a cost component of the model should be included.