Building the Foundation for a Standardized Approach to Progress and Outcome Monitoring across Substance Use and Addiction Services

Exploratory Phase

June 2022

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About HRI

Homewood Research Institute (HRI) is a registered Canadian Charity dedicated to transforming mental health and addiction treatment through research. We partner with leading scientists, universities, patients, and clinicians to improve care, services, and outcomes. HRI's charitable registration is # 86307 3334 RR0001.

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Executive Summary

Since 2014, Homewood Research Institute (HRI) has been working to develop, implement, and scale-up progress and outcome monitoring systems within live-in[1] treatment sites across Ontario. Previous literature and early learnings from HRI's work with the Homewood Health Centre in Guelph, Ontario, have demonstrated that routinely measured treatment outcomes, that go beyond the number of clients treated, can enhance accountability, guide resource allocation across the treatment sector, and support quality improvement by identifying what services work best, for whom, and in what contexts.

While the Homewood Health Centre has provided a unique and dynamic testing environment for a progress and outcome monitoring system, HRI recognizes that adapting or scaling up the model in other public- and privately-funded sites will require significant investment and engagement from healthcare leaders, treatment providers, and people with lived and living expertise.

From 2020-2021, HRI conducted a review of existing progress and outcome systems in Canada and internationally, and engaged relevant stakeholders through workshops to discuss the implications for standardizing such a system in Ontario.

More recently, and as captured in this report, HRI engaged leaders from six live-in treatment sites in Ontario with the goal to explore current practices related to program and outcome monitoring and interest and feasibility around taking a more standardized approach across the province. The chosen sites encompass a variety of treatment settings, geographical regions, and client populations to represent the diversity that exists in the sector.

Findings described in this report demonstrate the feasibility of standardizing measurement domains and time points across a variety of program sites and their respective progress and outcome monitoring systems. All program sites are at different stages of implementation, making it crucial that HRI creates opportunities for program leads to learn from one another's experiences.

In the coming year, HRI intends to support each program site with implementing and/or evaluating their progress and outcome monitoring system, with the ultimate goal of equipping clients, treatment providers, researchers, and decision makers with real-time, meaningful data that informs treatment and gives greater confidence that these services are improving lives across the province.

[1] Inclusive of residential and inpatient programs

1. Background

1.1 The Issue

The need to improve access to safe and effective treatment options for Canadians experiencing harm from substance use and mental illness, as well as the quality of care delivered, is well documented[2,3], as is the heightened urgency for solutions to increased substance use as a consequence of the COVID-19 pandemic.[4] In light of these trends, treatment providers in mental health, substance use health, and addiction are overwhelmed with demand for services, with many also having insufficient client-level data to inform service improvements. More specifically, gaps that pertain to live-in treatment sites across Ontario include the lack of a:

- Standardized set of core measurement tools;
- Standardized data collection procedures and processes that include follow up with clients for at least 12-months post-treatment;
- Data collection procedures and processes that are fully integrated within a provider's secure data storage and management practices to maintain confidentiality; and,
- Capacity for ongoing data analytics and reporting.

Standardized measurement tools and practices are fundamental to having evidence that is timely and of high-quality; such evidence can help identify areas of priority, inform resource allocation decisions, and, more locally, contribute to improved patient care. To address this gap, the International Consortium for Health Outcome Measurement (ICHOM) developed a person-centered minimum standard set intended for live-in and ambulatory treatment services. While the work of this international, multi-disciplinary group serves as a valuable resource—having been informed by empirical studies, and validated by healthcare professionals, and people with lived experience—there is no similar standard set that is currently being recommended or mandated for use at the provincial or national level in Canada. Furthermore, implementing and using any standard set of measures effectively requires significant investment. It is with these opportunities for improvement in mind that the Homewood Research Institute (HRI), and its partners, have sought to make an impact.

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[2] Ministry of Health. (2020). *Roadmap to wellness: a plan to build Ontario's mental health and addictions system.* https://www.ontario.ca/page/roadmap-wellness-plan-build-ontarios-mental-health-and-addictions-system

[3] Addictions & Mental Health Ontario (AMHO). (2019). *Residential Treatment of Adult Substance Use Disorders: Position Paper*. https://amho.ca/wp-content/uploads/Residential-Treatment-of-Adult-Substance-Use-Disorders-Position-Paper.pdf

[4] Dozois, D. J. A., & Mental Health Research Canada. (2021). Anxiety and depression in Canada during the COVID-19 pandemic: A national survey. *Canadian Psychology/Psychologie canadienne, 62*(1), 136–142.

1.2 The Recovery Journey Project

HRI's history in outcome measurement began in 2014 with The Recovery Journey Project. This initiative involved the development of a **Progress and Outcome Monitoring (POM)** system for treatment services at Homewood Health Centre, Guelph, Ontario. This system involved routine measurement of both client progress towards clinical goals during treatment (i.e., symptom reduction), and up to 12-months post-treatment, to document progress towards long-term goals (i.e., improved quality of life).[5,6]

Early learnings from this work demonstrated that routinely measured treatment outcomes, that go beyond the number of clients treated, can enhance accountability, guide resource allocation across the treatment sector, and support quality improvement by identifying what services work best, for whom, and in what contexts.

In addition, five features of the system were identified as being key to successful implementation; these included:

- Brief, self-administered, web-based questionnaires measuring various indicators of recovery at one, three, six, and twelve months post-treatment that are linked with routine screening and assessment practices (i.e., baseline assessment);
- Electronic data collection via online survey software and an automated email system;
- Client self-assessment of need for further supports at one, three, six, and twelve month time points;
- Capacity for data storage, management, and analysis; and,
- Translation of research findings for clients, treatment providers, researchers, the general public, etc.

Since The Recovery Journey Project was first launched, Homewood Health Centre's system has undergone multiple iterations. At the time of this report, the latest iteration provides each of Homewood's program teams, clinicians, and clients with accessible and timely data on progress towards expected treatment outcomes.

1.3 Scaling Up

While the Homewood Health Centre has provided a unique and dynamic testing environment for a progress and outcome monitoring system, HRI recognizes that adapting or scaling up the model in other public- and privately-funded sites will require significant investment and engagement from healthcare leaders, treatment providers, and people with lived and living

[5] Costello, M.J., Ropp, C., Sousa, S., Woo, W., Vedelago, H., & Rush, B. (2016). The development and implementation of an outcome monitoring system for addiction treatment. *Canadian Journal of Addiction, 7*(3), 15-24.
[6] Costello, M.J., Sousa, S., Ropp, C., & Rush, B. (2018). How to measure addiction recovery? Incorporating perspectives of individuals with lived experience. *International Journal of Mental Health and Addiction*, *18*(3), 599-612.

expertise. To lay a strong foundation for this work, HRI convened key stakeholders across the mental health, substance use health, and addiction sector to oversee and inform planning.

In March 2020, stakeholders gathered to hear what HRI had learned from developing and testing The Recovery Journey Project. The group then developed a shared vision and initial path forward, which included the initiation of HRI's review of existing POM systems in Canada and internationally. In December 2020, HRI reconvened stakeholders to share preliminary findings from the review and to discuss implications for standardizing a POM system in Ontario. These activities were completed with support from KPMG Waterloo and the KPMG Foundation.

In April 2021, HRI formalized plans to engage leaders from six live-in treatment sites in Ontario with the goal to explore current practices related to POM and interest and feasibility around taking a more standardized approach across the province. The sites that were chosen represent a variety of treatment settings, geographical regions, and client populations:

- St. Leonard's Community Services (Brantford);
- Dave Smith Youth Treatment Centre (Ottawa);
- Wayside House of Hamilton;
- Concurrent Disorders Unit in the Substance Use and Concurrent Disorders Program, The Royal Ottawa Mental Health Centre;
- Womankind Addiction Service, St. Joseph's Healthcare Hamilton; and,
- Homewood Health Centre (Guelph).

Consultations with these sites were completed with support from the Canadian Centre on Substance Use and Addiction (CCSA), KPMG Waterloo and the KPMG Foundation.

2. Purpose of this Report

This report captures HRI's exploratory work undertaken in 2021-2022 to meet the following objectives:

1. To document current progress and outcome monitoring practices across six diverse, live-in, substance use and/or concurrent disorders treatment settings in Ontario;
2. To promote the benefits of, and garner buy-in for, a common approach to progress and outcome monitoring;
3. To confirm the domains that would be most valuable to assess and at what time points in treatment; and,
4. To understand the barriers and facilitators to adopting a standardized approach to progress and outcome monitoring, readiness for implementation, as well as the resources and supports needed.

Findings described in this report demonstrate the feasibility of standardizing measurement domains and time points across a variety of program sites and their respective progress and outcome monitoring systems. All program sites are at different stages of implementation, making it crucial that HRI creates opportunities for program leads to learn from one another's experiences. HRI has the expertise to support each program site with developing their progress and monitoring system, which can come in the form of: recommendations around survey software and data storage practices; the development of administrative practices, policies, and procedures; internal communications and knowledge mobilization activities; and, formal evaluation activities that will capture what works well and inform changes to address what does not.

3. Key Activities

3.1 Selection of Program Sites

Public information on a variety of sites were gathered and reviewed. Details of interest included: program history and setting, client characteristics, approaches to treatment, length of stay, capacity (or number of beds available), transitions to other programs (e.g., community counselling), reported changes to program or capacity as a result of COVID-19, and any information pertaining to data collection and reporting. Relevant data were retrieved from ConnexOntario and each program site's website, including any published Annual Reports. Based on these factors, six program sites were selected to ensure representation of the diversity of the sector in Ontario, including various treatment settings, geographical regions, funding models, and client populations.

3.2 Preparation for Engagement

Introductory Meetings

In September 2021, leaders from the six program sites of interest were invited to partner with HRI to explore the potential for a standardized approach to POM. Leaders were provided with a background document explaining the value of POM and HRI's previous work in this area. Introductory meetings with each program site lead followed, with the HRI team providing more details about planned activities, team roles, and expected deliverables. All six program site leads agreed to participate in the project (hereinafter referred to as 'participants').

Development of Consultation Guides

Two rounds of individual consultations and one group consultation were planned to gather information about each treatment program. While the first individual consultation was focused on understanding current practices related to POM (**Appendix A**), the group (**Appendix B**) and second individual consultations were focused on implementation feasibility (**Appendix C**).

Consultation guides were developed with guidance from two frameworks: the *National Implementation Research Network's (NIRN) Hexagon: An Exploration Tool*, and the

Consolidated Framework for Implementation Research (CFIR). The Hexagon aids in the analysis of fit and feasibility to implement a particular intervention/innovation. The tool facilitates discussion from various perspectives across six domains related to both the program being implemented and the implementing site, including need, evidence, fit, usability, capacity, and supports.[7] The CFIR combines constructs from multiple implementation models that are related to effective implementation. These constructs are arranged across five domains including intervention characteristics, outer setting, inner setting, characteristics of individuals and process of implementation.[8]

3.3 Consultations with Program Sites

Individual consultations were held virtually from September - November 2021 and March - April 2022. Each consultation was facilitated by two or more members of the HRI team. Consultation guides were tailored to the program site based on previously collected information and any additional information that participants provided (e.g., intake or discharge questionnaires, process diagrams, measurement plans, etc.).

For the group consultation, which took place in March 2022, the HRI team presented preliminary findings and then facilitated a discussion with participants to seek agreement on core domains to be assessed and timepoints of measurement that were most valuable. All discussions were recorded for notetaking purposes and summarized for reporting.

4. Findings

Table 1 provides an overview of the six live-in treatment sites in Ontario that took part in this exploratory phase of the project, as documented in November 2021.

4.1 Current Practices around Progress and Outcome Monitoring

In total, 19 individuals across the 6 program sites participated in the first round of consultations. These individuals included directors, clinical leads, clinical leaders and managers, addiction counsellors, and quality improvement specialists.

Note: The spectrums shown in this section of the report are only a visual representation of collected qualitative data.

[7] Metz, A. & Louison, L. (2018). The Hexagon tool: Exploring Context. Chapel Hill, NC: National Implementation Research Network, Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill. Based on Kiser, Zabel, Zachik, & Smith (2007) and Blase, Kiser & Van Dyke (2013).

[8] CFIR Research Team-Centre for Clinical Management Research (2021). North Campus Research Complex, Ann Arbor, MI. The Consolidated Framework for Implementation Research – Technical Assistance for users of the CFIR framework (cfirguide.org).

Measures for Client's Baseline Assessment

Participants in the consultation were asked to report the measures they use at a client's point of admission to their program. At the time of consultation, and as shown in **Figure 1**, the GAIN-Q3 (Global Appraisal of Individual Need Quick3) and/or GAIN-SS (Short Screener) was being used by three program sites as the baseline assessment. The GAIN-Q3 is a screener used "to identify and address a wide range of problems in clinical and general populations." Domains covered by the GAIN-Q3 include: problems and service utilization, substance use, mental health (internalizing and externalizing problems), crime and violence, stress, physical health, school and work, and quality of life. It is important to note that not all program sites administered the GAIN-Q3 to clients, but that for some, clients or referring parties would complete it as part of the referral and enrollment process.

The other three program sites had their own set (or battery) of validated tools they used for baseline assessment. These tools were designed for completion with the assistance of a clinician or as a self-assessment. While each program site used a different mix of validated tools, they all included measures in the following domains: substance use health (substance type, frequency, severity, readiness to change, etc.), mental health, and quality of life.

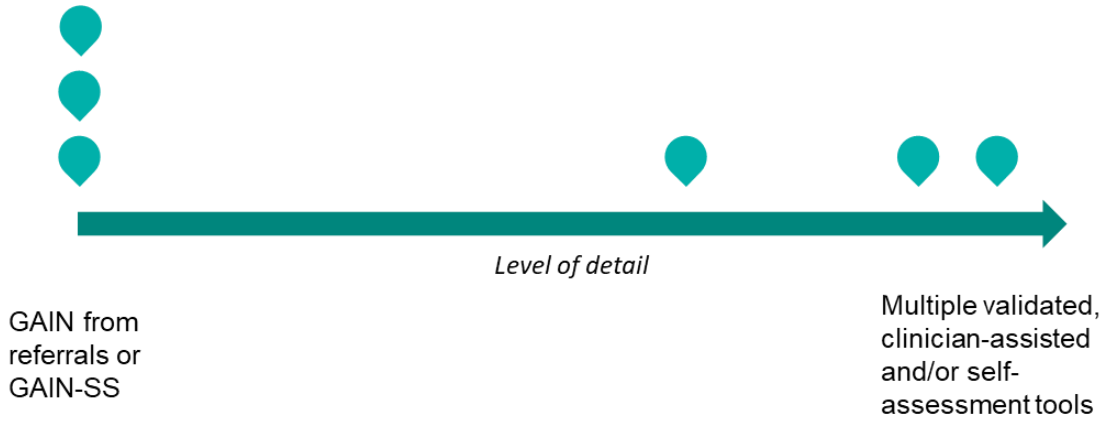

Figure 1. Spectrum of measures used for client's baseline assessment at 6 live-in treatment sites.

Table 1. Overview of participating live-in treatments sites in Ontario as of November 2021.

	St. Leonard's Community Services (Brantford)	Wayside House of Hamilton	Dave Smith Youth Treatment Centre (Ottawa)	Womankind at St. Joseph's Healthcare Hamilton	Substance Use and Concurrent Disorders Program at The Royal	Addiction Medicine Program at Homewood Health Centre (Guelph)
Clients	- All genders, 16+ - Approx. 15-20% homeless or precariously housed	- Men, 18+ - Approx. 45% from Hamilton and surrounding areas	- All genders, 13-21, and caregivers - Approx. 90% with multiple concurrent disorders	- Women, 18+ - Approx. 73% with a concurrent disorder	- All genders, 18+ - All have multiple moderate to severe mental health and substance use disorders	- All genders, 18+ - Majority seeking treatment for alcohol, followed by substances
Treatment program	- 5-week live-in program; shortened to 3-weeks during pandemic - Mix of individual and group supports	- Educational sessions, discussion groups, peer support - Approx. 3 months for 5 stages: orientation, core program, transition, relapse prevention, continuing care	- Modalities include individual, group, and family counselling - Stages: GAIN, up to 3-month live-in treatment, up to 3-month post-live-in continuing care - At day 45 of treatment, residents go on a home visit for 5 days	- 6-week treatment program - Mix of group sessions, individual counselling, leisure and peer-led programs	- Stabilization, assessment, diagnostic clarification, and treatment - Mix of individual and group-based programming - Program length depends on individualized treatment plan	- Streams: 1) Healthcare Professionals, 2) First Responders, Military & Veterans - 1 week for stabilization; 2-6 weeks for mix of individual and group therapy, peer support, etc.
Capacity	10 beds (6 for men, 4 for women)	22 beds; 16 during pandemic	- 24 beds across two campuses (14 beds for men, 10 beds for men); 13 during pandemic	26 beds	12 beds	80 beds
Transition to other programs	- Day treatment (5-week outpatient for all genders, ages 16+) - Withdrawal management - Continuing care (support group)	- Supportive Housing Program - Community case management can support transition back home	- Includes up to 3-month post-live-in continuing care	- Emergency Shelter - Addiction Supportive Housing - Aftercare "Living in Balance" - Youth Substance Use Program	- Assessment and Stabilization Unit - Day program, outpatient services, or community supports (including withdrawal management, live-in treatment supports)	- Aftercare through Homewood - Community supports

Measures for Client's Progress during Treatment

Participants were asked to describe any measurement activities that took place while a client accessed treatment, as well as what they viewed as ideal for the frequency and timing of assessing a client's progress.

As shown in **Figure 2**, five program sites reported that they do not formally measure progress towards desired outcomes during treatment, although they were all in agreement that having data that is comparable to what is measured at baseline and post-treatment would be useful.

While one site reported that they were in the process of adding a mid-point for data collection, the government-mandated OPOC survey was the only standardized way of gathering client feedback that was consistent across all program sites. The OPOC survey focuses on quality of care received across both community and hospital-based settings, and not a client's progress towards their desired outcomes.

With respect to what program sites viewed as ideal, participants agreed that: a) check-ins would happen on a weekly basis, with decreased frequency over time, and b) clients would have the ability to see their information and track their progress (i.e., measurement-based care).

Figure 2. Spectrum of measures used for client's progress during treatment at 6 live-in treatment sites.

Measures for Client's Progress Post-Treatment

At the time of reporting, the Addiction Medicine Program at Homewood Health Centre was the only program site with a system for collecting data from clients at discharge *and* after leaving treatment (**Figure 3**). This system includes the automated administration of an online questionnaire at the 1-month, 3-month, 6-month, and 12-month time points.

Most of the other program sites did not have the capacity to gather or compare baseline data with discharge or post-treatment data, with some exceptions. In many cases, clients transition into aftercare or the use of community supports, which can also be located in a different part of the province, making follow up a challenge.

Figure 3. Spectrum of measures used for client's progress post-treatment at 6 live-in treatment sites.

Processes for Data Collection, Analysis, Storage, and Use

A reoccurring theme across consultations was the lack of capacity for data collection and analysis for program sites based in the community, apart from mandated reporting requirements from the government. Completing the OPOC, for example, would be done with the support of addiction counsellors or peer supports. Not all program sites have a designated Quality Improvement Lead or similar role who could be responsible for submitting or reviewing the data collected.

On the other end of the spectrum were program sites with access to a data management or program evaluation team. These teams were responsible for gathering completed questionnaires, analyzing the data, and providing summary reports for clinicians.

Every program site used different vendors or software for data storage, in addition to each site having a different process for how data were analyzed and reported at the aggregate level, if they had the capacity to do so.

Practices and Measurement Outcomes Valued by Clinicians and Clients

Participants were asked to comment on what POM-related practices and outcomes were valued most by clinicians and clients. Practices valued by clinicians included access to real-time data and scores related to substance use and mental health that were streamlined, simple to interpret and translatable to treatment decisions. In addition, it was important to clinicians that assessments or tools used were easy for clients to understand and complete. Generally speaking, program leads believed that clinicians would be fine with using any outcome

measures as long as they were meaningful to clients and that their benefit to the client's progress was clear. Clinicians themselves reported that they would appreciate more evidence on whether or not specific aspects of their programming was effective (e.g., if client expectations had been met, if referrals made had been beneficial, etc.).

According to participants, clients valued outcomes that would give them a sense of their progress and changes to their overall quality of life, including their housing situation, ability to work, have healthy relationships, etc. Clients cared less about their score for specific substance use health and mental health assessments, unless it was accompanied with feedback. Of course, any further work in this area will require individuals with lived or living expertise to validate the domains that are of value to them, as was done with the ICHOM domains. This will ensure that client needs and goals are the focus of a standardized POM system.

Participants agreed that for both clinicians and clients, having access to real-time data with accompanying data visualizations would be a helpful and tangible way to show progression, which can be important to keeping a client encouraged or motivated throughout treatment. When clients can see the value in having data to inform their care, they will also be more willing to participate in data collection activities.

4.2 Other Considerations

Challenges and Barriers to Changing Current POM Practices

When participants were asked to identify potential challenges or barriers to changing current practices around POM, the most common themes were:

- Overburdened staff;
- Limited time and resources to support the development and uptake of any new policies, processes, required training, etc.;
- Lack of expertise in data collection and analysis;
- Lack of flexibility in changing current practices if a program site is embedded within a larger organization or hospital system; and
- Contact with clients after they leave treatment, particularly for program sites with a significant proportion of clients who are homeless or precariously housed.

Importance of Language Inclusivity and Accessibility

Program sites emphasized the importance of using measurement tools that are:

- Age-appropriate;
- Understandable and usable to someone with a Grade 6 reading level; and

- Written in English and Fresh, using equitable and inclusive language, not language that is stigmatizing.

Additional Factors that Impact a Client's Outcomes

When it comes to POM, participants noted a number of factors that impact a client's outcomes, even though they are not a core part of treatment. Examples include a client's fit with their counsellor, as well as the positive and negative dynamics between clients (e.g., level of conflict, sense of safety, peer support).

Another example is each client's recovery capital, or the internal and external assets that allow them to initiate and sustain recovery. A client's recovery capital can be shaped by their experiences gained in previous treatment settings, past trauma, the stability of their housing and relational support systems, community context, etc. Participants agreed that measuring these additional factors could be helpful to some extent, although keeping data collection to a minimum, so as to not burden the client, remains the higher priority.

4.3 Reaching Consensus on Measurement Domains and Time Points

In March 2022, the HRI team presented preliminary findings and facilitated a discussion with participants as a group. The HRI team proposed to focus on standardizing the measurement domains across the program sites, and in accordance with those recognized by ICHOM, rather than recommending a complete standard set (or battery) of measures for program sites to use. The domains recommended by ICHOM include:

- Quantity-frequency
- Symptom burden
- Health-related quality of life
- Global functioning
- Psychosocial functioning
- Overall physical health & well-being
- Overall mental health & well-being

Overall, participants supported this proposal. Program sites who already have a standard set were willing to make small adjustments to their questionnaires in order to suit these domains, if necessary.

The HRI team also shared ICHOM's recommended time points for measurement. After some discussion, participants came to a consensus that the time points shown in the bottom timeline in **Figure 4** would be a feasible set of minimum measurement time points.

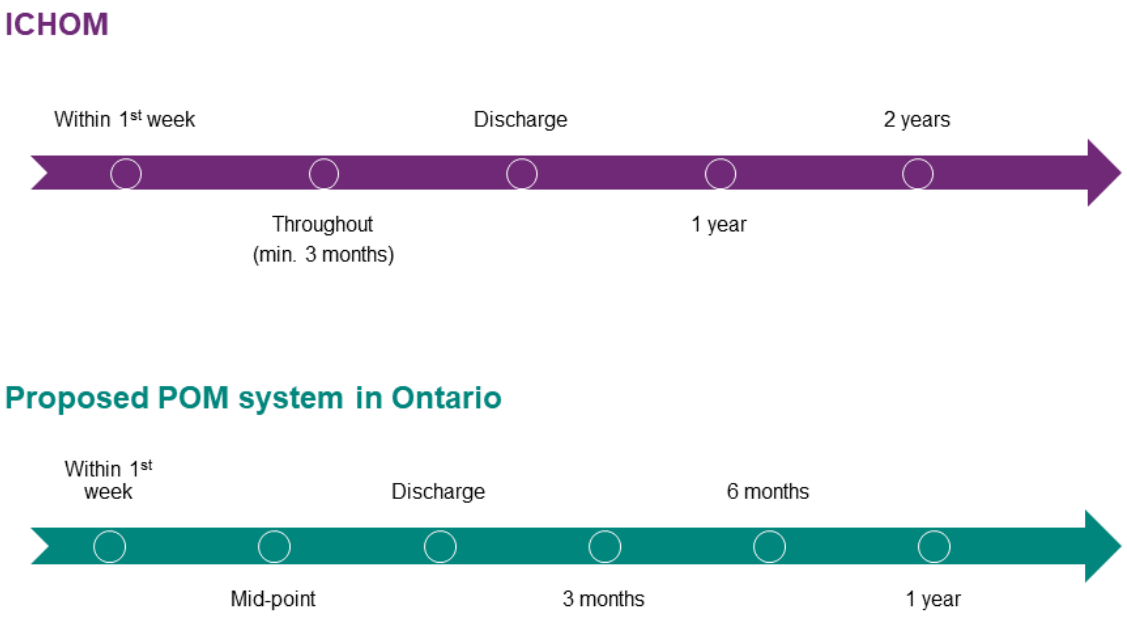

Figure 4. Proposed minimum measurement time points for 6 live-in treatment sites.

In coming to this decision, program leads took into account that each program has a different length of stay, with some programs being 5 weeks in length or less. Program leads found that assessment at intake within the client's 1st week of treatment was realistic, as long as the questionnaire was brief and would not conflict with retention efforts which are critical in a client's first few days. Keeping the questionnaire brief would also be crucial for clients who are experiencing withdrawal symptoms; depending on the program, clients could be in the process of detoxing or only recently gone through withdrawal at the start of their program. For program sites with a shorter length of stay, assessment would need to be completed as soon as possible.

Similarly, the exact timing of the mid-point assessment would be determined by the program site. Program leads agreed that having a mid-point assessment is conducive for implementing a treatment plan that is tailored and responsive to a client's changing needs. Mid-point assessments can also support transition planning, as most clients will have reached a level of stability and will feel ready to discuss next steps.

Program leads also determined that having a measurement time point sooner than 1-year post-treatment would allow for clients to receive supports earlier or be readmitted to the program if needed. Connecting with clients earlier on, at the 3-month and 6-month time points, would help keep clients engaged and make follow up at later time points possible. Trying to follow up with clients after more than 1-year post-discharge was anticipated to be very challenging; response rates would likely be low because the client's circumstances would possibly have changed. Program leads and clinicians had also learned from experience that having a sense of closure can be important for some clients to transition to the next chapter of their lives where

problematic substance use in no longer a part of their self-concept. Thus, doing any follow up after 1-year post-discharge could be more harmful than helpful for certain individuals.

Due to current resource and time constraints, program leads agreed that post-treatment data collection activities would have to be limited to virtual administration, with participants receiving email and/or text reminders to complete a questionnaire.

5. Next Steps

Over the next year, the HRI team plans to formalize partnerships with each of the six treatment sites in order to carry out an implementation or evaluation plan, the scope and details of which will depend on the stage of development of their progress and outcome monitoring system. The HRI team intends to facilitate knowledge exchange amongst program leads throughout the process, so that learnings across the program sites are shared.

The HRI team will also assemble a provincial advisory group, whose networks and expertise will be key to disseminating findings and building further support and capacity for scale up.

Ultimately, HRI's goal is to strengthen the work of treatment providers in mental health, substance use health, and addiction by equipping them with real-time, meaningful data that can not only inform the course of a person's treatment, but also gives clinicians, researchers, and clients greater confidence that these services are improving lives across the province.

Appendix A. Consultation Guide 1

Theme	Question	Probe
Opening, statement of purpose	To start us off, are you familiar with Ontario's recently launched *Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System*? This plan calls for a standardized approach to measuring performance of the current system, a call that is also echoed by both the Auditor General and Addictions and Mental Health Ontario. Have these calls for a standardized approach been discussed within your organization? Have they influenced your decision to explore POM or participate in these discussions with HRI? Our intention with the following questions is to draw more attention to this call and to consider how HRI can potentially play a role in supporting your organization. (Adapted from CFIR OS EPI #1)	
Introduction	Can you tell me about your role at [site]? What is your connection to the [treatment program]?	
Characteristics of treatment program	We have some information about your treatment program that we would like to verify with you. [Insert summary of known details.] Is there anything from that summary we are missing or should change?	Known details could include: - Client characteristics - Program details - Transition to other supports - Capacity/# of beds - Average LOS - Wait list (Connex)

	We would like to know a few other details about your treatment program. [Choose from list based on information needs.] Can you please comment on: - Program history for context (e.g., start and stop dates, changes in leadership, approach, etc.) - Average LOS (only if not mentioned above) - # of staff supporting this program - In what languages are your services provided?	
	Do you have a program profile and or logic model? (HRI POM Core Component)	
Current practices around POM	Are you currently monitoring any aspects of your client's progress during and/or after the program?	If yes, can you please describe for us what your current practice looks like? If no, why not? Or why did you stop?
	What measures are you currently using for a baseline assessment? (HRI POM Core Component)	
	What measures are you using to collect information about your clients' outcomes while enrolled in your treatment program? (HRI POM Core Component)	How frequently are data collected? How often do you think check-ins with clients *should* be? Who is responsible for administering data collection tools? For analyzing data? (HRI POM Core Component) How are data stored, reported, and/or used? (HRI POM Core Component)

		What considerations were made in choosing these outcome measures? (E.g., time to collect data, ease of method) If not collecting information, why not? Or why did you stop?
	What measures are you using to collect information about your clients' outcomes after they leave your treatment program (if any)? (HRI POM Core Component)	
	Are you aware of which outcomes are valued most by clients? What about staff? (Adapted from CFIR OS PNR #1)	
Client and staff perceptions and experiences with POM	Have you asked clients for feedback related to POM? How would you describe their perception and experiences around data collection for the purpose of understanding their progress? (CFIR OS PNR #6)	Please share specific stories or comments you have received from clients. (Adapted CFIR OS PNR #7)
	Have you asked staff for feedback related to POM? How would you describe their perception and experiences around data collection for the purpose of understanding their progress? (CFIR OS PNR #6)	Please share specific stories or comments you have received from staff. (Adapted CFIR OS PNR #7)
	Similarly, how would you describe your leadership's, staffs', and/or clinicians' perceptions around data reporting?	
	How do you think staff within your organization would respond to	

	implementing a standardized approach to POM? (CFIR OS PNR #4)	
	How do you think the individuals served by your organization would respond to implementing a standardized approach to POM? (CFIR OS PNR #4)	
Considerations for implementing a standardized approach to POM	What might be some challenges or barriers to changing your current practices around POM in order to take a more standardized approach? (Adapted CFIR OS PNR #5)	Refer to core components identified by HRI and ask how they feel about each one. Potential barriers could also include: - Limited time and resources - Low level of interest and/or initiative from leadership - Competing demands/priorities
	What barriers will the individuals served by your organization face to participating in POM? (CFIR OS PNR #5)	
	Are there any other quality improvement initiatives you are considering/already implementing that might influence uptake for this project? (HRI POM Core Component)	If so, how might these initiatives make it easier or more difficult to implement a POM System and to achieve the desired outcomes? (NIRN Fit #5)
	Are there age, gender-related, racial, ethnic, cultural or linguistic considerations you implement in your program that we should be aware of? (Adapted from NIRN Usability #6)	
Reflection and conclusion	As we come to the end of this consultation, I'd like to summarize what we've discussed so far. [Insert summary.]	

	Does that summary accurately reflect what we've discussed today?	
	Do you have any final or additional comments you would like to make?	

Appendix B. Group Consultation Guide

1. Slides 12 and 13 show recommended time points for measuring client outcomes. (Note: We are currently recommending domains for measurement (Slide 11), not specific measures for the time being.)

    a) Within your live-in treatment program, how feasible is measurement within a client's first week in treatment?

    b) Can a client's 'start' be defined as post-detox?

    c) Can you determine a mid-point for treatment at your site?

    d) How valuable would measurement/having client data be within 3 months post-discharge? Within 6 months?

    e) How valuable would measurement/having data across all time points be for clinicians? Clients?

2. Slide 17 shows a number of identified contributing factors that impact client outcomes, even though they may not be a core part of treatment. These factors include:

    - Recovery capital (e.g., experiences gained in previous treatment settings, community context)

    - Fit with counsellors

    - Dynamics between clients and staff

    a) Based on your organization's experience, is there anything we're missing from this list?

    b) Which, if any, of these factors are most important to you? Would they be important to measure in some way?

    c) Do you have any suggestions for how we can take these factors into account?

3. From the perspective of your program site, what are some advantages of using a person-centered minimum standard set of outcome measures across the province?

4. Is the vision for a minimum standard set missing any features or components needed to be effective?

5. What kinds of supports would you need to implement and/or refine your current POM system?

    - E.g., data analysis support, implementation support, internal training

    - External vs. internal supports already embedded within your organization

Appendix C. Consultation Guide 2

Theme	Question	Probe
Perceived fit of POM System	As you know, we've been conducting these consultations with the purpose of exploring the potential for a standard set of outcome measures in a variety of mental health, substance use health, and addiction treatment settings. In the coming months, our goal is to solidify an implementation plan with each partner site under a MOU. Do you agree with the proposed domains to be prioritized for a standard POM system?	
	In the group consultation we heard there would be more value in having follow-up sooner after discharge when patients may be more easily contacted, and when the benefits of the program are still recent. Can you please let us know what your preferred time point would be for follow-up after discharge?	
	HRI has acquired modest funding/resources to support this POM project and partner sites, thanks to KPMG and continued support from CCSA. HRI also plans to pursue grant funding with your organization as a potential partner. Assuming that your organization agrees to a MOU with HRI to continue this initiative… Does your site employ or have access to staff who could support implementation? (Adapted from NIRN Capacity #2-4) If so, please describe: - # of FTE, plus their education, level of experience - Cultural and language match with population they serve	If not, what kind of staff support would you require? Would your preference be to have access to a centralized resource person based at HRI (supporting all partner sites) or an internal staff member that is designated to this project?

Perceived capacity to implement POM System and supports needed	What capacity do you have with respect to technology (e.g., Voxco survey software), and data storage? (NIRN Capacity #9-11)	If little to none, how could HRI potentially support your organization with this?
	What administrative practices, policies, or procedures would have to be developed or refined to support the use of POM System? (NIRN Capacity #5, 8)	How could HRI potentially support this?
	What kind of internal communications and/or knowledge mobilization would you want to support implementation? E.g., coaching, broad recommendations, a step-by-step guide, prescribed measures, implications for staff, etc.	
Reflection and conclusion	Given today's discussion and our plan to pursue MOUs with all the partner sites for this initiative, are you still interested in participating?	Do you have any concerns with proceeding in this initiative with HRI?