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ROSC in Michigan: An Interview with Deborah Hollis, Director, Office of Recovery Oriented Systems of Care

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Introduction

Many of the early publications on addiction recovery management (ARM) and recovery oriented systems of care (ROSC) focused on work underway in the State of Connecticut and the City of Philadelphia. Recently that work has expanded in states and cities across the country, adapting itself to widely diverse cultural settings and economic and political constraints. One such area of concentrated development is the State of Michigan. In June of 2014, I had the opportunity to interview several people about the work underway in this state. In this first interview, Deborah Hollis offers the perspective from the Michigan Department of Community Health.

Bill White: Deborah, perhaps we could start by you describing your current position.

Deborah Hollis: Thank you Bill. First let me say how excited I am to have an opportunity to talk about what we're doing in Michigan. The interviews that you've been doing are serving a great purpose in shining a light on recovery efforts and bring tremendous value to the field as transformation continues. For a little over a year, I have served as the Director of the Office of Recovery Oriented Systems of Care located within the Behavioral Health and Developmental Disabilities Administration, Michigan Department of Community Health. Before our reorganization, I served as the Director of the Bureau of Substance Abuse and Addiction services for four years. The Michigan Department of Community Health consists of three large administrations, the Behavioral Health and Developmental Disabilities, Medical Services, and Public Health, among others. The Office of Recovery Oriented Systems of Care is responsible for ensuring the concepts of wellness and recovery are integrated into behavioral health services and supports. In addition, I have responsibilities for substance abuse prevention and treatment

block grant program implementation, and, statewide problem gambling services. The establishment of the Office of Recovery Oriented Systems of Care is significant for our state and I'm proud to serve in this role.

Bill White: Could you briefly outline the history of ROSC efforts in Michigan?

Deborah Hollis: I would be happy to. And thanks Bill for allowing me to go down memory lane a moment. In 2009, we began our ROSC efforts by discussing the implications of developing a recovery oriented system of care in Michigan. Actually our very early beginnings started with you Bill and our regional ATTC. You might recall those early Recovery Management presentations that you did at our annual state Substance Abuse Conferences. There were also evening dialogue and visioning sessions that you and Lonnetta convened with our regional coordinating agency directors. I'm also remembering how you introduced us to Dr. Arthur Evans in Philadelphia and how our ATTC arranged for a two-day technical assistance visit to Philadelphia to learn and observe their system. A team from Michigan participated. I represented the State of Michigan and Lonnetta Albright, the ATTC, Dr. Calvin Trent, Detroit Health Department and Andre Johnson, Detroit Recovery Project. Detroit was embarking on recovery transformation at the time. We had the privilege to learn from Dr. Evans, Roland Lamb, Bev Haberle and so many others there in Philadelphia. This trip encouraged us to proceed and proved to us that this could indeed be done. When we returned from Philadelphia I would say there were two parallel tracks going on. At the State level we focused on understanding the system and what ROSC is--a value-driven framework and how we could use that framework to shift our system from an episodic, acute care approach to one that focuses on long-term recovery, health and wellness. It was at this point that Great Lakes ATTC introduced us to Dr. Ijeoma Achara, one of your protégés and trusted colleagues. She guided us through the transformation process using the three

alignments (conceptual, practice and contextual) as a blueprint; the same that was used in Philadelphia. We engaged her services and expertise and began first by educating all of my staff and then a statewide ROSC summit for stakeholders. We continued to focus on educating our partners, stakeholders and the workforce through conferences, trainings, focus groups and various team meetings.

Dr. Achara helped us to create and develop our statewide Transformation Steering Committee which had major role in our transformation efforts and continues to exist as a recognized committee within our current integrated behavioral health structure.

The second and parallel process that was occurring was at the community or grassroots level in a few of our counties. In addition to Detroit, transformation initiatives were occurring in Washtenaw, Genesee and of course Kent County (Grand Rapids). These were our early adopters. And while my office focused on subjects such as administration, financing and regulations; as well as workforce development across the state, these early county systems were developing their community networks both formal and informal. This included peers recovery coaches.

We have systematically moved forward with ROSC on the SUD side. Now with our state's effort to integrate our entire behavioral health system we need to bring all of our systems (SUD, Mental Health and Prevention) to a level where we share a vision of recovery that would move us from a system of silos to one system with a goal of helping our citizens, families and communities to become healthy. We've been working from a Recovery construct for over five years now, with a deliberate and intentional goal to transform the substance use disorder (SUD) system and to simultaneously build on this framework for mental health services and prevention.

Bill White: And what were some of the strategies that you have found to be effective in promoting ROSC?

Deborah Hollis: The key for us has been getting the buy-in from our stakeholders. Again, those early sessions we held with you were critical in helping to get the buy-in from our county-based leadership. And along with the treatment system we included prevention in our ROSC efforts. It was a new concept for our preventionists and many didn't understand how primary prevention could fit within a ROSC. They consistently asked how prevention and recovery could go together. So, we took the time and devoted resources to bring prevention groups together for dialogue and consensus-building. And there was a prevention subcommittee as part of our TSC. That was key. We brought our county coordinating agency directors, prevention coordinators, providers, persons in recovery and interested stakeholders together to discuss Michigan's publicly funded substance delivery systems. And with the assistance and support of our ATTC we not only consulted with Dr. Achara, but also brought in and sought expertise from Connecticut's former Commissioner Dr. Thomas Kirk and Dr. Arthur Evans from Philadelphia; who as you know are the architects and pioneers of ROSC. And of course you have been with us from the beginning to help show how all of the pieces fit together. I can also say that we had the support of the federal government including Dr. Westley Clark at CSAT who presented on Recovery at several of our state substance abuse conferences and ONDCP who selected Detroit, Michigan as the site for the 2012 National Celebrate Recovery Walk and Rally. Michigan was also selected to participate in ONDCP's ROSC Learning Community to share our experience.

Bill White: And what would you say are some of your most important achievements to date with the transformation effort?

Deborah Hollis: One major achievement was getting consensus and approval of our "Implementation Plan for Substance Use Disorder Services System Transformation" in 2011. In our plan we provided an overview of ROSC, our vision, framework for guiding our recovery transformation and set goals for

the next three years. This has truly been a journey for us. As our SUD system was transforming, Michigan's entire behavioral health system began to implement changes to embrace population health. The feedback we are getting is that behavioral health leaders want to better understand the concepts and are employing practices to support ROSC. We now have ROSC values and strategies integrated into our contract language, including guiding principles and ROSC-related performance measurements. We are seeing funds being spent on recovery support services, which is an important part of the success story. Initially the funds were there however, providers and counties were not accessing those funds. Other achievements include our State's website, fact sheets, quarterly newsletters that are all within the Office of ROSC; development of SUD expanded benefits for Medicaid Expansion (Healthy Michigan) and ROSC principles included in Behavioral Health contracting. Another accomplishment worth mentioning are the partnerships we continue to develop with academic institutions in Michigan. One example is Marygrove College in Wayne County who came together with the Detroit Health Department, Detroit Recovery Project, Detroit Rescue Mission Ministries, SUD providers in that system and the ATTC to create a 2-semester course and internship for Recovery Coaches.

Bill White: What were some of the sources of early resistance to ROSC that you encountered?

Deborah Hollis: It took some time to develop a shared vision with all of our stakeholders. As I mentioned earlier, prevention initially didn't see their role. Our treatment providers were concerned that they would lose clients and income because we were focusing on services outside of treatment settings. And it just took time to increase stakeholder understanding of the differences between ROSC and a traditional system. We worked long and hard to increase awareness and understanding of

the ROSC concepts. Stakeholder buy-in was key.

Bill White: Now, tell me about the involvement of the state in the Grand Rapids area.

Deborah Hollis: Sure. Grand Rapids became very interested in ROSC and wanted to begin transforming their system of care. As I mentioned, they were one of our early counties to engage in this shift. We supported them in their first ROSC summit in 2009. They've done a remarkable job under the leadership of Mark Witte and resources provided by the Great Lakes Addiction Technology Transfer Center. I understand from Lonnetta that Mark and the leaders of their RCO (Recovery Allies) are co-training with the ATTC around the region to share their stories, successes and challenges. I think that's important. People need to see that this is the right path to follow and yet it is not easy. It takes time. It takes partnerships and it takes patience. Grand Rapids is definitely an example of what can happen in a community when everyone is involved with a shared vision and intention. And so key to their story is the involvement of those from the recovery community.

Bill White: How would you compare the ROSC work in Grand Rapids area with other areas of Michigan?

Deborah Hollis: What distinguishes Grand Rapids /network 180 is how well they have kept the conversation going and kept a high level of energy to sustain their transformation efforts. In April they had a second Summit. This time around they are an expanded region that includes multiple counties. Building on their first four years, Mark engaged a group of stakeholders to discuss services to persons with SUD, barriers and how systems work together more effectively to achieve ROSC. They have also successfully engaged primary care. This region has worked to create a sustainable ROSC system by addressing housing, working with Primary Care, and promoting Peers and Recovery Coaches

working in the system. It's been amazing to witness what they are doing.

Bill White: Based on your experience with ROSC in Michigan, do you have recommendations for other officials in other states looking to embark on similar systems transformation projects?

Deborah Hollis: Well, you need key leaders—people who have the energy and the fortitude to sustain this work at all levels and in all systems, not just behavioral health. You need people involved from areas as diverse as housing, criminal justice, child welfare, disabilities, veterans and primary healthcare. You must be able to promote behavioral health as a component of continuing care at a level of intensity that has never been done before. And there has to be an understanding that the service team will need to expand. In the former system there were treatment providers (addiction and mental health). That workforce needs to expand and include not only clinicians but also non-clinical team members such as peers and coaches as well as primary care. And it wouldn't hurt to get connected to the ATTC in the region. They have tremendous experience, expertise and networks to help systems (small and large) with the change process.

Bill White: Based on your experience in Michigan, do you feel like recovery is a good conceptual bridge to help integrate mental health and addiction services?

Deborah Hollis: Yes, I do. It is an area where we can work together while still respecting distinct differences between addiction recovery and the mental health recovery. In Michigan, Mental Health has had billable recovery services for years. This became a reality for addiction services in 2006 with a change in state administrative rules. In June 2013, The Office of Recovery Oriented Systems of Care was established. This organizational change brought addiction and mental health recovery services together under one unit. This is creating training opportunities and internal

dialogue to establish a shared vision of recovery. Our vision is to create “a future for the citizens of the State of Michigan in which individuals and families live in healthy and safe communities that promote wellness, recovery and a fulfilling quality of life.”

In October 2014, by law, administration of SUD services will be fully integrated with mental health.

Bill White: What do you see as the next steps for ROSC in Michigan?

Deborah Hollis: The next steps for ROSC in Michigan is to use it as a guiding framework as our behavioral health system continues to transform – first we will continue to educate leadership and stakeholders on how ROSC is defined, implemented and measured within the behavioral health system and second we intend to increase support of peer based recovery support services, expanding the focus to include integrated behavioral health and primary care services.

Bill White: What’s been the role of peer recovery support services within the ROSC efforts in Michigan?

Deborah Hollis: Creation of a peer culture remains an important role for us. We have had a commitment to peer and recovery support services since the very beginning. This commitment is listed as one our ROSC 16 guiding principles. I’m happy to say that I have a person with lived experience on my staff. This is important to me because it allows us to be inclusive and benefit from

their recovery at the state level. We’ve included peers on our Transformation Steering Committee and encourage paid peers on staff at the service level and in leadership roles. For a while, we’ve had two distinct silos—SUD and mental health—in which peers have been providing support services. We’re now working to combine that effort through joint training initiatives and co-occurring programs. We’re looking at more pilots to place peers and recovery coaches into primary care settings. Our Peer Specialists are certified. Most of our Recovery Coaches were trained under CCAR [Connecticut Community for Addiction Recovery]. Overall, we’re still at the initial phase of trying to build a bridge, where appropriate, between the peer specialist and recovery coaches.

Bill White: Deborah, thank you for taking this time to share a state-level perspective on the Michigan experience.

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