

Person-Centered Recovery Planning Initiative

Evaluation Report: FY2013





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Person-Centered Care

Person-centered care is one of the six aims of healthcare quality established by the Institute of Medicine (2001) and is defined as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions." In patientcentered organizations, patient and family input and engagement are both welcomed and sought out as an integral part of the operations and culture, with patients and families participating on committees, boards, and advisory groups to ensure an active role in all decisions related to services and service improvement (Balik, Conway, Zipperer, & Watson, 2011). Patient-centered care does not replace but complements and contributes to clinical treatment through effective partnerships and communication (Frampton et al., 2008). A growing evidence base shows that person-centered care is essential to improve clinical, financial, and service outcomes as well as satisfaction with care (Balik et al., 2011; Browne, Roseman, Shaller, & Edgman-Levitan, 2010; Adams & Drake, 2006). Research in physical care settings demonstrate that when patients are actively involved in their care, they are better able to manage complex chronic conditions, seek appropriate assistance, have reduced anxiety and stress, and shorter lengths of stay in the hospital (Balik et al., 2011). Health care for mental and substance-use conditions has embraced many facets of person-centered care through inclusion of consumer, family, and advocate voice, the use of peers and peer support in facilitating recovery, and inclusion of the individual in decision making (Institute of Medicine [IOM], 2006). Many evidence-based and promising mental health practices and interventions promote person-centered care, choice, and self-directed care (Adams & Grieder, 2005; Adams & Grieder, 2014; Cook et al., 2009; Cook, Terrel, & Jonikas, 2004; Mueser et al., 2002). Although research on shared decision-making and person-centered care for individuals living with mental illness is relatively new (Adams & Drake, 2006) studies are beginning to demonstrate effectiveness (Stanhope, Marcus, Ingoglia, & Schmelter, 2013; Walker, Darer, Elmore, & Delbanco, 2013).

Person-Centered Planning

Person-centered planning (PCP) is a well-known approach that has been employed successfully for over 25 years in the disability fields (O'Brien & O'Brien, 2000). It is a best practice for designing effective networks of services and supports for individuals that enable a higher quality of life including community integration (Claes, Van Hove, Vandevelde, Van Loon, & Schalock, 2010; Tondora, Pocklington, Gorges, Osher, & Davidson, 2005). Person Centered Planning (PCP) within a Recovery Oriented Care Continuum and has been described by Adams and Grieder (2005, 2013) as "a collaborative process resulting in a recovery oriented treatment plan; is directed by consumers and produced in partnership with care providers and natural supporters for treatment and recovery; supports consumer preferences and a recovery orientation" and "a strategy to promote and foster whole health that builds on an integrative approach to assessing and understanding each person's needs and helps each person articulate and realize his or her unique individual wellness vision." PCP provides a framework for individuals to partner with care providers to select services that meet their needs in moving towards a life goal. It responds to critiques of the system, particularly that people are expected to fit passively into existing services with no role in the organization or planning of their treatment services (Dowling, Manthorpe, & Cowley, 2007; Sanderson, 2000). Ultimately, person-centered planning is learning through shared action, finding creative solutions through partnership, and problem solving to create change in the individual's life, in the organization, and in the community (Sanderson, 2000).

The use of PCP in mental health systems gained momentum after release of the President's New Freedom Commission on Mental Health Report (2003) and during the SAMHSA Mental Health Transformation State Incentive Grants in 2005. Since then, 11 states (Connecticut, New York, California, Maryland, Massachusetts, North Carolina, Wisconsin, Michigan, Delaware, Oregon, and Virginia) have worked toward various levels of PCP implementation in their systems, with Texas supporting PCP

implementation at pilot sites beginning in 2011. Although the use of PCP in mental health systems is more recent, a randomized controlled trial in 10 community mental health centers found that PCP was associated with greater engagement in services and higher rates of medication adherence, provided support for orienting treatment to a client's life goals and allowed the client greater control over services received to reach their goals (Stanhope et al., 2013).

The practice of PCP, and recovery oriented practices in general, can only occur within a system and organizational culture that embraces the principles of recovery-oriented, person-centered care (Davidson, et al., 2009; Tondora, et al., 2005). Factors cited for slower PCP implementation include system and organizational culture, strict funding and service infrastructure, as well as high staff turnover and lack of supervision to PCP. An examination of factors that hinder and facilitate PCP in the traditional service system may be required before PCP can be fully implemented in the mental health system (Claes et al., 2010; Dowling et al., 2007) and full PCP implementation will take time, particularly in a state as large and diverse as Texas. Supportive policies, a dedicated implementation approach over a realistic timeframe (Fixsen, Sandra, Blase, Friedman, & Wallace, 2005), and positive outcomes associated with PCP will provide evidence to support further adoption of PCP within the service system and for each individual receiving service (Stanhope et al., 2013; Dowling et al., 2007).

DSHS

The Mental Health and Substance Abuse (MHSA) Division of the Department of State Health Services (DSHS) has embraced a vision of "Hope, Resilience and Recovery for Everyone" aligning with national recommendations to develop systems of care with policies, services, practices, and beliefs that support and facilitate recovery. To further commit to this vision, in 2012 the name of the state's public mental health service delivery system was changed from Resiliency and Disease Management (RDM) to Texas Resilience and Recovery (TRR). TRR is a patient-centered approach rather than a "disease management" model. TRR acknowledges that adults living with mental health issues have strengths and natural supports that should be built upon in services and that providers have the opportunity to support individuals in reaching their life goals (Department of State Health Services [DSHS], n.d.).

DSHS has embarked on a number of transformational initiatives to ensure that recovery and resilience are fundamental principles of Texas' public mental health system. In particular, the use of the Adult Needs and Strengths Assessment (ANSA) for comprehensive assessment that is linked to evidence-based and promising practices in service delivery ties to outcomes measured by recovery indicators that relate to life goals. The primary implementation concern cited by staff in the Texas PCP implementation is that PCP takes too much time given current caseloads and new initiatives (Figure 7). Rather than being understood as the overarching roadmap that links the comprehensive assessment to evidence-based services to measurable recovery outcomes, the PCP process is viewed as a standalone "documentation activity" only used for billing and meeting audit requirements. When systems and organizations fully employ PCP processes and partner with clients, PCP serves as an umbrella that promotes:

- Increased cultural competence through understanding each person's unique life experience and life goals;
- Increased engagement and participation in services due to focus on achieving an individual's
 identified goal and having a plan that helps them "see" the steps needed to move toward the
 goal;
- Direct alignment of the comprehensive ANSA to the content of the plan;
- Increased choice for and decision making by the person in services to address barriers and reach goals;

- Use of evidence-based practices and services in interventions based on understanding of the
 person's goals and needs (e.g. Illness Management and Recovery that includes identifying and
 developing individual goals or Seeking Safety to address trauma);
- Focus on meaningful service user outcomes in a wide range of life domains (e.g. employment, housing, community linkages) which are often either the individual's goal or related to achieving their goal;
- More rigorous documentation to meet regulatory and billing requirements; and,
- Active, appropriate use of peer specialists in the workforce (Grieder & Tondora, 2013).

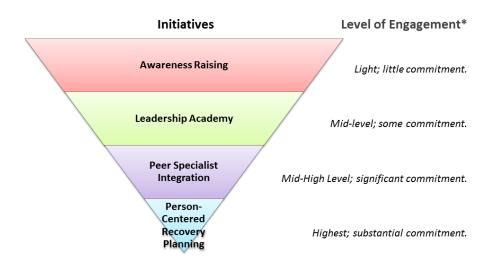
To support person-centered system transformation in the public mental health system, the Department of State Health Services has funded Via Hope's Recovery Institute, Person Centered Recovery Planning Implementation and contracted with the Texas Institute for Excellence in Mental Health to evaluate this initiative.

Via Hope and The Recovery Institute

Via Hope Texas Mental Health Resource was established in 2009 out of the Texas Mental Health Transformation Project. Providing resources, training, and technical assistance, Via Hope serves adolescents and adults in recovery, their family members, and mental health service organizations to create a recovery- and resilience-oriented system of care. Via Hope created a Peer Specialist Training and Certification Program in federal fiscal year 2010 (FY2010), which trains individuals in recovery to effectively use their lived experience to help other individuals progress in their recovery journey. As a way to market this new workforce to organizations, Via Hope developed a Peer Specialist Learning Community for Texas mental health agencies to participate in. Through this process, Via Hope discovered the importance of creating a recovery-oriented environment at the organizational level, with peer specialist integration being one piece of that. Thus, Via Hope created the Recovery-Focused Learning Community (RFLC) in FY2011.

From the RFLC, Via Hope launched the Recovery Institute (RI) in FY2012 with the overall purpose of promoting "mental health system transformation by (1) helping organizations develop culture and practices that support and expect recovery, and (2) promoting consumer (aka peer, person in recovery), youth/young adult, and family voice in the transformation process and the future, transformed mental health system. The Via Hope Recovery Institute interfaces with transformation efforts facilitated directly by Texas Department of State Health Services Mental Health and Substance Abuse Division and is a significant component of the Division's transformation strategy. The Institute is funded through DSHS and the Hogg Foundation for Mental Health and evaluated by The University of Texas at Austin Center for Social Work Research" (Via Hope, 2013). The RI concurrently addresses the needs of multiple organizations through the use of a 4-tier model (Figure 1), requiring different levels of commitment from participating organizations.

Figure 1
Model of Recovery Institute Structure



*Participation readiness considered during application process.

Awareness Raising

The Awareness-Building project is the least intensive of the four RI projects, with the goal of increasing awareness of recovery and system transformation concepts. It consists of a didactic webinar series and a monthly reading and dialogue portion called "Recovery Reads." This project is open to anyone, but individuals are required to register before participating (Via Hope, 2013).

Recovery Institute Leadership Academy

The Recovery Institute Leadership Academy (RILA) requires some commitment and supports sites in strengthening organizational recovery orientation through shared leadership. This project serves as an entry point for organizations who have not yet participated in Via Hope Initiatives. Organizations are asked to focus on 2 of the 4 identified domains: access and engagement; continuity of care; community mapping, development, and inclusion; and identify and address barriers to recovery (Via Hope, 2013). Organizations interested in participating in RILA go through a competitive application process before being accepted. In FY2013, 6 organizations (3 LMHAs and 3 state hospitals) participated.

Peer Specialist Integration Project

The next tier of the Recovery Institute is the Peer Specialist Integration Project (PSI), which requires a higher degree of commitment from participating sites than the Awareness Raising or RILA projects. The aim of this project is to assist participating organizations in strengthening their recovery orientation through the integration of peer specialists. Participating sites are expected to demonstrate change across the following five domains: organizational culture; funding peer specialist positions; recruitment and hiring of peer specialist; peer support staff role definition and clarification; and supervision and career advancement (Via Hope, 2013). There is a competitive application process for PSI. In FY2013, three LMHAs participated in the PSI Project, one of which participated on its own, one of which partnered with a peer-run organization, and another which partnered with a non-profit supportive housing organization.

Person-Centered Recovery Planning

The most intensive project within the Recovery Institute is the Person-Centered Recovery Planning (PCRP) Initiative. This project requires systemic changes at the organizational level that fundamentally change the way mental health providers traditionally work with individuals. Through working with persons in recovery collaboratively, individuals are able to take ownership of and become more engaged in their treatment planning process.

Because of the time- and resource- intensive nature of this project, Via Hope limited participation to this program to two sites (one state hospital and one LMHA) in FY2012 with the addition of two new sites (two LMHAs) in FY2013. LMHAs were asked to select a clinic or unit focusing on clients in DSHS Service Package 3, which offers pharmacological management, medication training and support, psychosocial rehabilitation, supported employment, and medical services.

Participating Sites

During federal fiscal year (FY) 2013, three Local Mental Health Authorities (LMHAs) and one state hospital participated in the PCRP project, with one of the LMHAs and the state hospital continuing participation from FY2012. Table 1 below presents the clinics, units, and teams that participated in the project in FY2012 and FY2013 by site.

Table 1
Participating sites for FY2012 and FY2013

		Participating Clinic/Unit/Team	Participating Clinic/Unit/Team FY2013			
Site	Site Type	FY2012				
Austin State Hospital	State	Specialty Services E/F	Specialty Services C/D			
Austin State Hospital	Hospital	Specialty Services E/F	Adult Psychiatric Services 6			
Austin Travis County Integral Care	LMHA	n/a	Community Recovery Team			
Bluebonnet Trails Community	1.5.411.4	Daywad Dayle	Round Rock,			
Services	LMHA	Round Rock	Caldwell, and Gonzales			
Hill Country Community MHDD	LMHA	2/2	Kerrville and San Marcos			
Centers	LIVITA	n/a	Refrville and San Marcos			

Austin State Hospital (ASH)

Austin State Hospital (ASH) covers a catchment area of 38 counties, admitting over 4000 individuals a year and maintaining a daily client population of 292. ASH is comprised of 14 units serving individuals with a wide range of needs and services. The first units to participate in the PCRP initiative in FY2012 were Adult Specialty Services Units E and F (SS EF), which serve hearing impairment and intermediate cognitive impairment populations. In FY2013, ASH spread PCRP practices to Specialty Services Units C and D (SS CD), which serve dually diagnosed adults with severe cognitive impairment, and Adult Psychiatric Services Unit 6 (APS 6), which serves individuals experiencing acute distress.

Austin Travis County Integral Care

Austin Travis Country Integral Care (ATCIC) serves individuals in Travis County. They operate 16 facilities, with a new integrated care clinic scheduled to open in Dove Springs in November 2013. ATCIC began participating in the PCRP Initiative in FY2013 but had begun implementing person centered care planning and concurrent documentation in the two years prior. For the Via Hope PCRP initiative, ATCIC selected the Community Recovery Team which primarily provides SP3 services in the city of Austin.

Bluebonnet Trails Community Services

Bluebonnet Trails Community Services (BTCS) became involved in the PCRP Initiative as a pilot site in FY2012. BTCS provides services to individuals in 8 counties in Central Texas, encompassing the areas

north, east, and south of the Travis County. Participation in the PCRP Initiative began at the administrative home of BTCS in Round Rock in FY2012. During FY2013, BTCS slowed implementation in Round Rock while diffusing PCRP practices to clinics in Caldwell and Gonzales counties.

Hill Country Community MHDD Centers

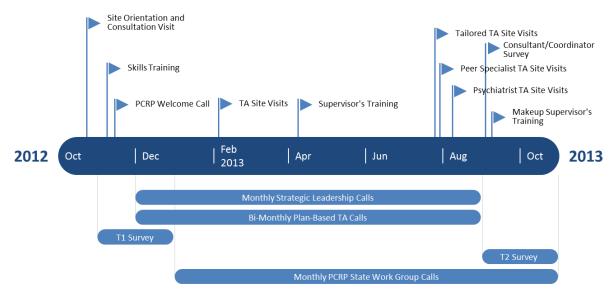
Hill Country Community MHDD Centers (HC) first participated in the PCRP initiative in FY2013. This organization has an immense catchment area, covering 18 counties spanning from east of Austin to the Texas-Mexico border counties of Val Verde and Kinney. The two clinics currently participating in the project are located in Kerrville, which is the agency headquarters, and San Marcos.

Data Collection

Data collection for the FY2013 PCRP Initiative took place over a period of 13 months, between October 2012 and October 2013. Sources of the information collected were the training and technical assistance events that constituted the PCRP project in addition to staff and client surveys administered at two time points and a consultant and coordinator survey (

Figure 2). Training and technical assistance events included a PCRP welcome call, site orientation and consultation visit, a 2-day skills training, a technical assistance site visit, a supervisor training (and makeup supervisor training), tailored technical assistance site visits, peer specialist site visits, psychiatrist site visits, monthly strategic leadership calls, bi-monthly plan-based technical assistance calls, monthly cross-site state workgroup calls, as well as observational notes and/or feedback surveys associated with each of the training or technical assistance events.





Implementation Science

Implementation and Intervention Processes and Outcomes

Implementation science calls for a delicate balance between policy and practice changes and associated research findings. Thus, putting a new program into practice is a two-pronged process consisting of implementation processes and outcomes and intervention processes and outcomes, all of which are important to the long-term sustainability of the program. Fixsen and colleagues (2005) define implementation as "a specified set of activities designed to put into practice an activity or program of

known dimensions." Based on this definition of implementation, an intervention is the activity or program of known dimensions.

In PCRP, the implementation process is the effort organizations are engaged in to incorporate personcentered care across the entire organization and the associated implementation outcomes are changes in practitioner behavior and changes in organizational policies, procedures, and cultures to create an environment that establishes the infrastructure necessary to support and sustain person-centered practices. The intervention process is the person-centered treatment meeting and recovery plan that is created through a collaborative process with the treatment team and person receiving services. The desired improvement in client recovery is the intervention outcome. Because the Texas PCRP program is early in its development, established just 2 years ago, the implementation processes being put into practice are still being defined and evaluation using this model is being applied retrospectively to the data collected in FY2013. It often takes years of implementation site development before meaningful outcomes can be observed (Fixsen et al., 2005) and several more years before adjustments to the model can be made. Implementing a new program is an ongoing, iterative process that requires patience and persistence (Schofield, 2004). As the PCRP program becomes more well-defined in the coming year, evaluators will be able to better assess fidelity to the implementation and intervention processes and measure the impact of the processes on implementation and intervention outcomes.

Essential Components of Implementation

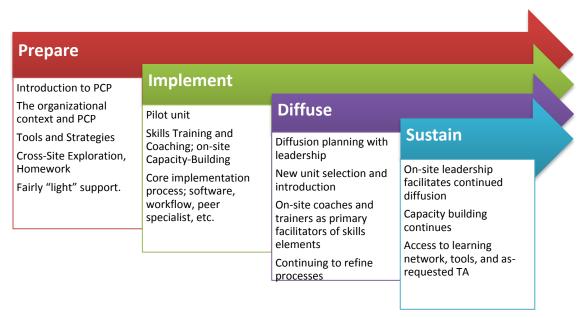
The five essential components of successful implementation include: source, destination, purveyor, feedback, and influence. The *source* is the ideal model of the practice that is being implemented (Fixsen, Blase, Naoom, & Wallace, 2009). Well implemented programs will achieve high fidelity to the model. The *destination* is the organization and/or practitioner that are putting the source into practice. The *purveyor* is the party actively attempting to implement the model practice with fidelity and effectiveness at the implementation sites. A *feedback* loop is established in order for the implementation sites to provide purveyors with information regarding progress being made and potential barriers or challenges. The *influence* is the context with which the program or practice is being implemented. This may include social, political, economic, or historical settings that could potentially impact individual practitioners, the organization, or the broader system.

In Texas, the PCRP model and associated practices are continuing to be defined and evaluated. The model presented by Adams and Grieder (2005) represents the foundation of the PCRP model. However, the model must be tailored to best meet the needs of organizations in Texas. The four organizations currently participating in the initiative and the practitioners implementing the practice at these organizations represent the destination component of PCRP in Texas. Via Hope is the purveyor of PCRP in Texas. It is responsible for establishing the statewide infrastructure to support the adoption of PCRP practices at the site level. Through internal staff and hired consultants, Via Hope provides training, technical assistance, coaching, and support and encouragement to the participating organizations. Over time, Via Hope intends to build internal staff and organizational capacity such that sites will rely less on external supports and more on internal supports at the implementation sites. Monthly leadership calls constitute the formal feedback mechanism by providing a forum for site leadership teams to share progress being made in addition to challenges and barriers that are being encountered. In terms of influence, each organization operates within a unique context that affects implementation success. Via Hope is conscious of these influences at the individual site level as well as the environmental landscape set forth by the Department of State Health Services when making programmatic decisions about PCRP implementation.

Phases of Implementation

Just as person-centered care requires practitioners to assess an individual's readiness and stage of change, program implementers must understand the unique characteristics, strengths, and barriers of the site they are working with and identify readiness to move forward in the implementation process. To do this, Via Hope developed a model (Figure 3) that delineates 4 phases for PCRP implementation: prepare, implement, diffuse, sustain. The model is structured to be a step-up process, with each phase serving as a building block for subsequent phases. Program implementers should allow between 2 to 4 years for carefully planned and well-executed programs to be fully implemented and sustainable (Fixsen et al., 2005; Metz & Bartley, 2012). The four phases of PCRP implementation are described below.

Figure 3
Via Hope's model of PCRP implementation



Source: Via Hope, 2013

Prepare

In the prepare stage, sites are introduced to concepts of recovery-oriented and person-centered care. Tools and strategies are shared to allow sites to gain a basic understanding of the PCRP process and what full program implementation would entail in a learning collaborative format. Abilities of sites to meet minimum requirements are assessed in addition to potential implementation barriers. During this phase, decisions regarding program participation are made.

While no sites were actively in the prepare phase during FY2013, Via Hope will be more intentional in introducing PCRP concepts to other sites participating in less intensive Recovery Institute projects. Because these sites are actively working on building awareness of recovery principles, cultivating shared leadership, and integrating peer specialists at the organizational level, they represent ideal sites to incorporate into the prepare phase of the PCRP initiative. At the request of DSHS, in FY2014 Via Hope will introduce PCRP concepts to sites not currently participating in Via Hope Initiatives.

Implement

Once organizations have decided to move forward in program implementation, resources to ensure a successful implementation process are identified and gathered, staff are trained and begin to build

competencies, core implementation processes (i.e., peer specialist integration, software changes to support a person-centered plan) are discussed and established. Program implementers and leadership teams use data and experience to assess organizational readiness for broader diffusion of the program before moving to the diffuse phase.

At the end of FY2013, the three LMHAs were in the implement phase. Although they received skills training and coaching and have worked on the core implementation processes necessary to successfully integrate PCRP practices, they have not yet demonstrated the capacity to maintain current levels of implementation or spread PCRP to other units within the organization. Although BTCS did diffuse PCRP to Caldwell and Gonzales counties in FY2013, Round Rock lost some gains of the first year due to complete turnover of SP3 intensive case managers at the site. Via Hope will work with each of the sites at the beginning of FY2014 to discuss readiness to spread to other teams or sites within the organization using a Diffusion Assessment Tool. If any organization is found to be capable of diffusing practices to other sites or teams, they will move from the implement phase to the diffuse phase.

Diffuse

Sites enter the diffuse phase once it has been determined that the foundation required to disseminate practices more broadly has been established. Lessons learned are applied as the program spreads and processes are refined in order to best integrate the new practice in a variety of settings. Internal trainers and coaches are trained to support long-term sustainability of practices, as sites begin to rely less on external consultants, coaches, and trainers. Plans for sustainability are discussed.

ASH is currently the only site that has begun moving into the diffuse phase. Each year ASH has diffused the initiative to a new unit within the hospital, beginning with Specialty Services E and F in FY2012, spreading to Specialty Services C and D and Adult Psychiatric Services 6 in FY2013, and diffusing to Child and Adolescent Program Services (CAPS) and Adult Psychiatric Services B in FY2014. They are beginning to demonstrate the capacity to maintain skills in previously participating units through the use of structured coaching teams. Future evaluation activities will determine if PCRP practices and outcomes are maintained in the implementation units.

Consultants and coordinators were asked to rate each of the sites on their readiness for spread on a 10 point scale (1=not at all ready; 10=very much ready). Overall, sites received a score of 4.5 out of 10 on

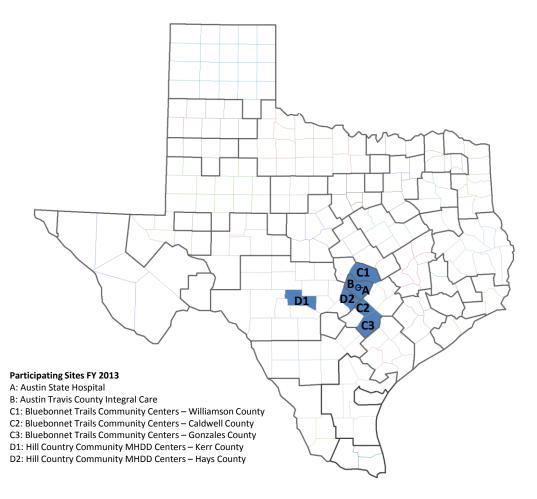
the readiness to spread domain, with scores ranging from 2 to 6 for each site. On the Time 2 staff survey, respondents were similarly asked how ready the organization was to roll out PCRP to other units. Staff were more optimistic about the diffusion potential of sites compared to the consultants/coordinators with a score of 6.9 out of 10 (range=3 to 10).

Staff at all sites rated themselves more ready (M = 6.9) than consultants/facilitators rated site readiness (M = 4.5) to diffuse PCRP.

Staff were also asked to provide advice as PCRP is rolled out to other units at the organization. Suggestions to Via Hope and consultants include provision of additional training and support on PCRP concepts, narrative summary, plan elements, team processes, implementation strategies, and differences between traditional treatment and person-centered planning. Staff also called for more consistency, patience, and positivity on plan-based TA calls. A few respondents requested that training be provided to all staff members prior to roll out to increase buy-in and facilitate change in organizational culture. Regarding recommendations to the sites, staff highlighted the importance of additional time, financial resources, and stakeholder buy-in and leadership. Staff mentioned the salience of including the person receiving services, peer specialists, and PNAs in the planning meeting for a richer

understanding of the individual. Staff pointed out the need for those implementing PCRP to be patient with themselves as they learn new practices and concepts and to be teachable. Self-evaluation and follow-up on plans and progress notes were also indicated as being an area of improvement for future implementation efforts. Finally, TA calls and coaching were also identified as important to implementation.

Figure 4
Map of participating sites by phase of implementation



Sustain

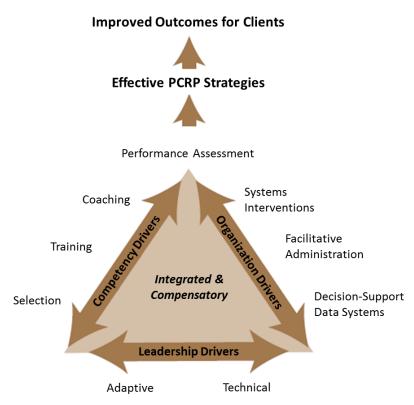
A site enters the sustain phase when plans for sustainability are in place with adequate financial and administrative supports established to maintain the program or practice. Quality management structures are established to monitor the program for fidelity to the model and allow decisions to be data-driven. In FY2014, Via Hope will begin helping sites think about long term sustainability such that practices can be diffused and maintained beyond Via Hope involvement and support. Currently, no sites are ready to move into this phase, which aligns with implementation science research that suggests practices take approximately 2-4 years before long-term sustainability is achieved.

Implementation Drivers

Implementation drivers are the foundational components essential to successful program implementation (Fixsen et al., 2005; Metz & Bartley, 2012). There are 3 sets of implementation drivers

competency drivers, organization drivers, and leadership, which are integrated and compensatory in nature. A program may still be implemented effectively even in the presence of a weak driver; an implementation driver that is strong and incorporates all or most of its designated best practices can overcome weaknesses in other drivers. When drivers are brought together in a cohesive manner, highly effective strategies are implemented and lead to improved outcomes at the client level (Figure 5).

Figure 5
PCRP Implementation Drivers



Modified from Metz & Bartley (2012)

Competency Drivers

The use of competency drivers is intended to build upon and improve the skills of the practitioners who will be providing the intervention. This set of implementation drivers affects practice level changes and consists of selection, training, coaching, and performance assessment.

Selection

If a program is to be effective, competent staff members with the necessary knowledge, skills, and abilities must be selected for implementation. Staff selection criteria may include educational background, relevant training and experience, skills (social and professional), knowledge of concepts and philosophies underlying the program, and other personal characteristics (NIRN, n.d.; Fixsen et al., 2005; Metz & Bartley, 2012). Once basic qualifications have been identified, organizations can develop methods for recruiting, interviewing, and selecting appropriate staff. Best practices for staff recruitment and selection include (Fixsen, Blase, Naoom, & Duda, 2013):

- Designation of lead person for development and monitoring of staff selection
- Clear job descriptions for each position
- Identification of minimum job requirements related to practices that will be implemented

- Interactive interview process to assess knowledge, skills, and abilities
- Knowledgeable interviewers
- Establishment of a feed-forward process to provide interview data to other staff members, administrators, and coaches
- Establishment of a regular feedback process for tracking staff turnover, staff evaluation data, training data etc. to evaluate the effectiveness of the staff selection driver

To select organizations for PCRP implementation, Via Hope included a number of suggestions for staff recruitment and selection during the application process and during training and consultation. Requirements for an organization to apply for PCRP implementation included: an Executive Sponsor (Center Executive Director / Hospital Superintendent) to apply and participate in PCRP activities; prior participation in Via Hope or similar recovery-oriented system change initiatives; identification of a change unit (hospital) or clinic (LMHA) serving adults (specifically clients receiving service package 3 at the LMHA); creation of a change team with a leader interested in supporting this effort; peer representation on the change unit and employment of more than one certified peer specialist as staff; commitment of 2-4 hours per week for PCRP work; participation in data collection; an Executive Sponsor hosted half-day introduction to PCRP, 2-day PCRP skill building training, and 1-day PCRP refresher; peer specialist participation in training on peer support in PCRP; team lead and change unit staff participation in two PCRP consultation calls with expert coaches each month; and the leadership team participation in one leadership call each month.

Each organization was required to designate a leadership and change unit team. Composition of the leadership team varied across the sites, but Via Hope requested the team include the executive sponsor, change team lead, the unit/clinic/SP3 director, medical (nursing or psychiatry), IT, quality management, professional development/training, peer support, and any additional staff identified by the organization that would be needed to make the changes necessary to implement PCRP. Composition of the change team also varied across sites (particularly from hospital to LMHA), but Via Hope requested that the LMHA teams include the change team lead, unit director, case managers or rehabilitation specialists, psychiatrist, peer specialists, nurse, and any other staff involved with the specific recovery plan (e.g. supported employment staff). Via Hope requested that hospital teams include the change team lead, unit director, psychiatrist, social worker, psychologist, nurse, peer specialist, education rehabilitation, and any other staff involved with the specific recovery plan (e.g. chaplain, occupational therapist, psychiatric nurse assistant, etc.). The change team lead was also in a leadership position at the organization and served as the liaison to the executive sponsor and the primary point of contact with Via Hope. To date, only one organization has established a staff position (i.e., developed a position and job description specific to recovery activities) that is dedicated to supporting the PCRP initiative and this is likely related to this organization developing training, coaching, and diffusing PCRP more quickly to other units than the other participating organizations.

Staff Knowledge of PCRP Concepts. During the Time 2 survey, staff responded to questions intended to assess knowledge of person-centered concepts and practices. Overall, staff demonstrated a high degree of knowledge of PCRP principles, with 82.4% responding correctly to at least 14 of the 16 questions. While this finding is positive, as it indicates staff are knowledgeable in PCRP concepts and practices, it should be interpreted with caution as the survey was administered at Time 2 only. Therefore, training received or participation in PCRP cannot be directly linked to staff knowledge. If knowledge of PCRP concepts is deemed a salient requirement of staff involved in implementation, sites should consider this as a screening criteria in recruiting and selecting staff in units or levels of care where PCRP will be implemented or as a pre-/post- assessment of knowledge gained as a result of training and consultation.

Staff Participation and Engagement. Staff participation was documented through staff attendance in PCRP activities over 12 months (training, technical assistance, twice a month plan consultation calls). In general, there was a decrease in the number of staff participating in all activities as the PCRP project progressed. However, this decrease must be examined within the context of each organization and each of the activities. Participation in PCRP plan-based technical assistance calls varied across organizations, but each team did have consistent participation by particular staff that had been formally or informally designated "PCRP leaders". Two organizations had more staff participate and more consistent participation over the course of implementation than the other two organizations, although this did not always relate to greater improvement in documentation. All organizations had high participation in the PRCP 1-day orientation and 2-day skills training. All organizations also had required key staff attend the supervisor training. As implementation progressed, site specific technical assistance was offered toward the end of the fiscal year (July and August). These were more difficult for Via Hope to organize and had less participation of key staff. It is not clear if the technical assistance was viewed as not valuable or if organizations were simply experiencing initiative fatigue due to the significant number of changes beginning in the new fiscal year (e.g. new assessment, service packages, implementation of best practices, and incentive payments tied to outcomes). Demonstrating how PCRP ties all of these elements together and how specific elements of PCRP are billable will be critical to engagement and effective implementation.

Psychiatrist Involvement. Psychiatry represents a field that is important to involve in the PCRP process as physicians and other professionals often have a strong influence on the treatment team, particularly when it comes to decision making about medication and psychosocial interventions (CalMEND Guide Workgroup, 2008). Furthermore, most psychiatrists were trained in the traditional medical model, perhaps reflecting a division of the workforce who may be more resistant to person-centered practices and a collaborative treatment and recovery planning process. In fact, one of the top 10 concerns surrounding the implementation of person-centered care planning is, "Emphasizing patient choice inevitably devalues clinical knowledge and expertise" (Tondora, Miller & Davidson, 2012).

Psychiatrist involvement varied by site and within each site. Observational notes from the technical assistant site visits targeted at psychiatrists indicate that this workforce has been making small changes towards the implementation of PCRP, but resistance to full adoption of practices remains. Overall, the consultants and coordinators rated psychiatrist involvement lowest out of nine domains important to PCRP (M=3.94 out of 10), representing an area in which all participating sites could improve (Figure 6). While the percentage of staff members reporting that PCRP devalues clinical knowledge and experience increased from Time 1 to Time 2 on the staff surveys (Figure 7), less than 15% selected it as one of the top 3 concerns at either time point, suggesting that those trained in the traditional medical model (e.g., psychiatrists) might be open to adopting person-centered practices as staff do not perceive that as a major barrier to PCRP implementation.

Figure 6
Average Via Hope consultant and coordinator ratings of sites

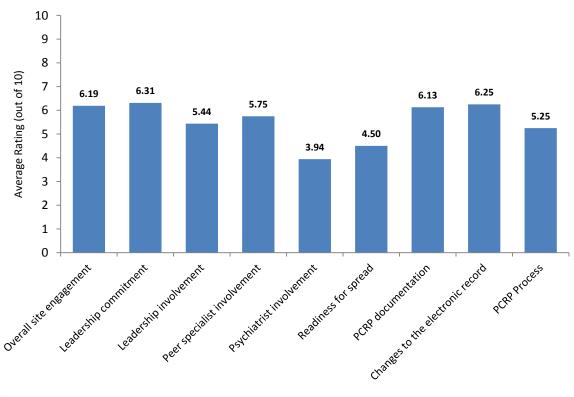
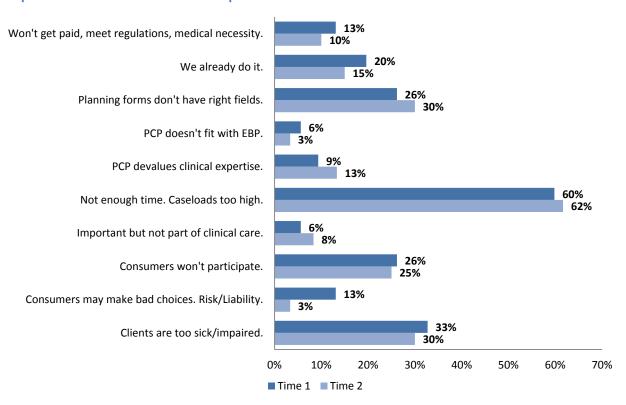


Figure 7
Top 10 staff concerns about PCRP implementation



Peer Specialist Involvement. Peer specialists are individuals with lived experience who have initiated their recovery journey and are willing to assist others who are in earlier stages of the recovery process. Peers have the ability to form deep connections with clients and can assist them in identifying and achieving recovery goals. Staff rated peer specialists as being critical to PCRP, with an average rating across sites of an 8.84 on a one to 10 scale (1=not at all important, 10=very important). Despite the

perceived importance of peer specialists by staff, consultants and coordinators rated peer specialist involvement across sites 5.75 out of 10 (Figure 6). Further, only 35.9% of clients reported working with a peer specialist at Time 1. Findings indicate that although peer specialists are considered a critical element to PCRP,

Staff rated peer specialists as critical to PCRP (8.84 on a 10-point scale), but improvements could be made to better integrate peer specialists into the PCRP process.

improvements could be made to further integrate this critical workforce into the process.

Coaching competencies. One of the sites developed PCRP coaching competencies in collaboration with the consultants. The site plans to use these competencies to determine who would be a good fit in the coach position and to evaluate coach performance. In the next year, Via Hope and the evaluation team will be creating competencies, which could be utilized in a number of ways, such as in an information packet for the coaches training to inform sites who would be most appropriate to attend, to standardize the coaches training, and to assess coach performance and fidelity to the PCRP coaching model.

Leadership Call Notes on Selection. Out of all the implementation drivers, selection was discussed least frequently on the leadership calls. On Via Hope PCRP team calls, consultants stressed the importance of considering the knowledge, skill, and ability level of staff members when selecting coaches and the importance of selecting staff with an organizational position and ability to lead the changes needed for PCRP implementation. Topics on calls related to staff included the role of peer specialists in the PCRP process, particularly with regard to meeting with the person receiving services prior to the planning meeting for goal discovery and discussing ways to involve the psychiatrist in the process given time demands. The issue of staff turnover emerged often on the leadership calls, as did hiring new staff members, job descriptions, competencies, and role clarification.

Training

Before a practice is implemented, practitioners must receive training on the intervention they are expected to implement. Training should provide background information on the theory, philosophy and values underlying the program as well as concrete components of key practices (NIRN, n.d.; Fixsen et al., 2005; Metz & Bartley, 2012). Beyond didactic sessions, training should provide a forum to practice new skills and receive feedback through role play in a safe environment. In addition, knowledge tests should be given pre- and post- training to assess the acquirement of new knowledge, skills, and abilities. Best practices for training include the following (Fixsen et al., 2013):

- Designation of a staff person to be held accountable for training quality
- Training is timely, that is, it is delivered prior to staff putting the new skill/practice to use
- Training is skill-based
- Trainers have received training and coaching
- Pre- and post- tests of knowledge/skills/abilities are administered
- Performance assessment measures collected and analyzed related to the training
- Establishment of feed-forward process that provides coaches and supervisors with training data
- Establishment of a feedback process that uses training data to inform selection and recruitment procedures

Via Hope-provided training. To introduce PCRP to staff at participating units, Via Hope offered a 1-day orientation to PCRP followed a month later by a 2-day intensive PCRP skills training. The one-day orientation introduced staff to PCRP, collected data from staff on their perceived PCRP implementation barriers and challenges, and observed a treatment planning meeting or conducted focus groups with clients receiving services to determine their perceptions of the use of person centered practices at the organizations. These data were used to inform the 2-day skills training and prepare consultants and Via Hope facilitators for the specific strengths, needs, and barriers at each organization (e.g. changes needed to the electronic health record, level of physician involvement, use of peer specialists in PCRP, current use of person-centered practices, etc). The 2-day training offered skill development on the process and documentation of PCRP. Staff practiced developing plans using client case studies, including developing a narrative summary (clinical formulation) including a clinical hypothesis, a life goal, a SMART objective, and appropriate interventions. The golden thread of medical necessity woven through the plan was emphasized to meet billing and documentation requirements. Evaluations of the 2-day training were conducted with staff at all organizations with consultants receiving high ratings (over 4 on all items using a 1-strongly disagree to 5-strongly agree rating scale) on items measuring consultant competency, usefulness of the materials used during training, and staff reported confidence in their ability to develop a person centered plan after the training.

In addition to the orientation and skills-training, Via Hope also provided training targeting peer specialists at the participating organizations, specifically how this workforce can be utilized within the PCRP process. The training participants indicated

they found the training valuable, the information useful, and the consultants knowledgeable and effective, however, including non-peer staff at the training may have strengthened the integration of the peer role into the PCRP process. Although peer specialists

knowledgeable and effective, however, including assistance was highly valuable with improvement in PCRP documentation supporting these self-reports.

work with clients on goal discovery at one site and discuss the PCRP process and administer a "Recovery Inventory" at another site, two of the participating organizations have yet to incorporate peers in a standardized fashion. Via Hope could apply lessons learned from the Peer Specialist Integration Initiative to assist sites in more fully integrating peers and DSHS could support this integration by identifying billable peer support interventions that support the PCRP process.

Overall, on the survey conducted at the end of the implementation period, all sites reported that the training and technical assistance provided by Via Hope was highly valuable, with the 1-day orientation receiving a rating of 8.4 out of 10, the 2-day PCRP Skills-Training receiving an 8.9 out of 10, and the peer specialist training receiving an 8.6 out of 10.

Site-provided training. Two of the sites have developed an in-house training curriculum to educate the staff on basic principles underlying person-centered and recovery oriented care and on how to write a person-centered recovery plan. At the end of FY2013, only one of the two sites had actually delivered the training; the other site is in the process of finalizing the curriculum. Both of the sites with an internal training curriculum participated in the PCRP project in FY2012, perhaps suggesting that staff involved in the initiative might not be comfortable training colleagues on person-centered care and recovery planning until they have been given ample time to develop their personal skillset. As organizations move through the PCRP implementation phases, Via Hope and evaluators should consider the optimal time in program development in which sites should create and deliver internal PCRP trainings.

On the Time 2 staff survey, sites requested that Via Hope provide training for trainers earlier in the implementation process so that the foundation of person-centered language and organizational culture can be laid out prior to the adoption of the practice.

Leadership Call Notes on Training. On the leadership calls, much of the discussion about training related to logistics (date, time, location, and agenda), participant requirements and/or recommendations, training content, and feedback after the training had been delivered. Leadership teams also asked for additional training to assist with staff skill development in writing the plans. For the two sites that have developed an internal PCRP training, feedback was provided when solicited by the site. Later on in the year, sites began thinking about the use of training to facilitate PCRP diffusion and sustainability. Other trainings, such as iLearn modules, Anasazi, ANSA, and evidence-based practices were mentioned, albeit infrequently.

Coaching

Basic skill levels are assessed during the staff selection process and expanded upon during training, but are not fully ingrained until individuals are provided an opportunity to practice and apply skills in a real-world setting. The combination of training and coaching is critical to affecting sustained behavior change (NIRN, n.d.; Fixsen et al., 2005; Metz & Bartley, 2012; Fixsen et al., 2013). Therefore, it is imperative for practitioners to receive coaching through the provision of additional information about the practice, advice, and encouragement. Best coaching practices include (Fixsen et al., 2013):

- Designation of an individual who is responsible for the development and monitoring of coaching
- Coaches who fully understand the new practice; written coaching service delivery plan
- Use of multiple sources of data to provide feedback to practitioners (e.g., observation of practitioners using innovation, review of records, interviews with individuals working closely with practitioner)
- Established coaching structure and process through regular review of coaching service delivery plan adherence and demonstrated improvement in practitioner skill as a result of coaching
- Use of multiple sources of information to provide feedback to coaches (e.g., satisfaction surveys of those being coached, coaching of coaches, performance assessments of coaches)
- Established feedback process that uses coaching data to inform staff selection and training drivers

During bi-monthly plan-based technical assistance calls, sites provided intake assessment data, a narrative summary, and the recovery plan to consultants who then reviewed and provided feedback in a coaching format. After the supervisor training, staff members at the sites began to assume coaching responsibilities while consultants "coached-the-coaches." During the calls, a TA Call Summary Form (Appendix A) was completed by evaluators and reviewed by consultants to document strengths, areas for improvement, and overall ratings on specific elements of the narrative summary and recovery plan. Findings based on the Summary Form are presented in a subsequent section (Performance Assessment, page 20). The number of coaches per site ranged from 3 to 14.

After the call, the consultants provided feedback to the coaches. Sites varied in their receptivity to feedback; some sites demonstrated an eagerness to receive feedback after the calls and valued the discussion format, others requested written feedback via email, while others simply did not make the time to discuss their coaching skills. Establishing standardized feedback procedures would ensure consistent feedback across sites and provide information on why sites differ in implementation success.

The coaching feedback indicates that the coaches generally struck a nice balance between providing strengths-based feedback and offering areas for improvement to those who developed the recovery

plan and narrative. While coaches were commended on their efforts in providing concrete examples to improve plans and ask questions of those on the call to encourage critical thinking, the consultants encouraged using these two strategies more frequently. It was also noted that as coaches continue to get comfortable with PCRP concepts, these things will come more naturally to them. Areas for improvement for the coaches included better time management, allowing teams to discuss how the plan could have looked different overall (i.e., structured differently, had a different goal, included information from the narrative summary in the plan itself, etc.), highlighting the importance of language (i.e., is the plan written in a way that the individual receiving services can understand it), and ensuring that the discussion is a review of the plan and the process rather than a clinical case consultation. Similar to the feedback provided to coaches, the coaches were not evaluated in a standardized fashion this year. Once competencies have been developed, coaches should be trained and evaluated on the competencies to ensure a good fit. As sites continue to implement practices, they should begin to assume responsibility for training and evaluating coaches using quality improvement processes.

On the Time 2 staff survey, respondents reported both plan-based TA calls (m=8.4 out of 10) and the coaching feedback received after the calls as being highly valuable (m=8.9 out of 10). Open-ended feedback on the staff survey indicates that while sites felt the coaching feedback was comprehensive and helpful, they would like the conversation to be geared more towards the performance of the coach, rather than about the case itself or how the team approached the case. A standardized coaching feedback process should focus primarily on coach performance.

Leadership Call Notes on Coaching. Leadership teams expressed appreciation for the plan-based TA calls, as it provided an opportunity to apply the concepts and skills learned through training to "real" situations. They found the repeated exposure to concepts helpful, particularly for staff who were struggling to learn and apply person-centered practices. After the supervisor's training, coaching responsibilities transitioned from the consultants to the team members and leadership teams expressed some anxiety with the transition. However, site-based coaches assumed the role with relative ease and found the coaching feedback provided immediately after the call by the consultants useful to the development of their coaching skills. One of the sites did not provide much feedback (positive or negative) related to the coaching feedback session; however, this site typically received coaching feedback via email as the coaches did not have time or make time to discuss over the phone. As Via Hope standardizes the coaching feedback in the upcoming year, they should consider requiring sites to attend a coaching feedback session immediately after the call, as coaches value the feedback and believe that it solidifies their coaching skills.

Performance Assessment

To assess the skills and associated outcomes reflected in staff selection criteria, taught in training, and reinforced through coaching, staff performance assessment measures should be established to ensure overall skill application quality (NIRN, n.d.; Fixsen et al., 2005; Metz & Bartley, 2012; Fixsen et al., 2013). Organizations should use multiple sources of data to assess performance and share data collection instruments and assessment tools with staff to maintain a sense of transparency. While performance assessment is a fidelity measure related to staff performance and, therefore, falls into the competency driver domain, it can inform organizational and leadership drivers. Leaders are ultimately responsible for program success so they must be aware of staff performance and make programmatic changes as needed based on fidelity assessments. Further, organizational drivers contribute to overall staff performance and facilitative administration, data systems, and systems interventions can all be improved if regular feedback loops are established between these organizational drivers and performance assessment findings. Implementation fidelity often serves as a moderating variable between a program and its intended outcomes (Carroll, Patterson, Wood, Booth, Rick, & Balain, 2007).

Through a fidelity assessment, researchers are able to link unintended or poor outcomes to either poor program implementation or innate program inadequacies. Best practices related to performance assessment (fidelity) include the following (Fixsen et al., 2013):

- Designation of a lead person to be accountable for measuring and reporting on performance assessment
- Transparent processes that inform staff on how performance assessment will be used
- Performance assessment measures are correlated with outcomes
- Performance assessments conducted on regular basis with all practitioners implementing the intervention
- Establishment of practical and efficient measurement and reporting system
- Assessment measures include context, content, and competence
- Assessment measures include multiple data sources
- Participation is recognized positively and is not a punitive process; and established feedback process that uses performance assessment data to assess coaching effectiveness and improve coaching processes

Plan-Based TA Calls. On the bi-monthly plan-based technical assistance calls, TA Call Summary Forms were completed to assess important elements of the narrative summary and recovery plan. Domains evaluated in the narrative summary include individualization, strengths, barriers/functional impairments, natural supports, cultural supports, client/family driven, stage of change, hypothesis, overall impression, and discharge criteria (hospital only). Elements of the recovery plan include link of plan content to hypothesis, goals, objectives, medical necessity, use of strengths in plan, interventions, and self-directed and natural support actions. For each element of the narrative summary and plan, evaluators assigned a rating using the following guidelines: 2 = excellent; 1 = good; 0 = n/a to consultation; -1 = minor issue; and, -2 = major issue. In addition to ratings, written feedback on strengths and areas for improvement for each plan element was provided.

Overall, sites excelled in creating individualized narrative summaries, identifying natural supports (but not necessarily including them in the planning or the plan), linking plan to hypothesis, including a self-selected life goal, and demonstrating medical necessity (Figure 8). Areas where sites tended to struggle included stage of change, hypothesis, and developing objectives and interventions. Regarding stage of

change, staff frequently did not explicitly identify the stage, even when hinted at in the narrative summary. When the stage of change was explicitly stated by the plan writer, there was occasionally disagreement among the team, which typically created a richer understanding of the individual by call end.

When comparing documentation trend lines from FY2012 to FY2013 it is evident that organizations are beginning the project with stronger documentation skills and demonstrate greater improvements across time

Staff appeared to have the most difficulty identifying stage of change when the individual was working on both mental health and substance use barriers, but were advised that individuals may be in a different stage in each area.

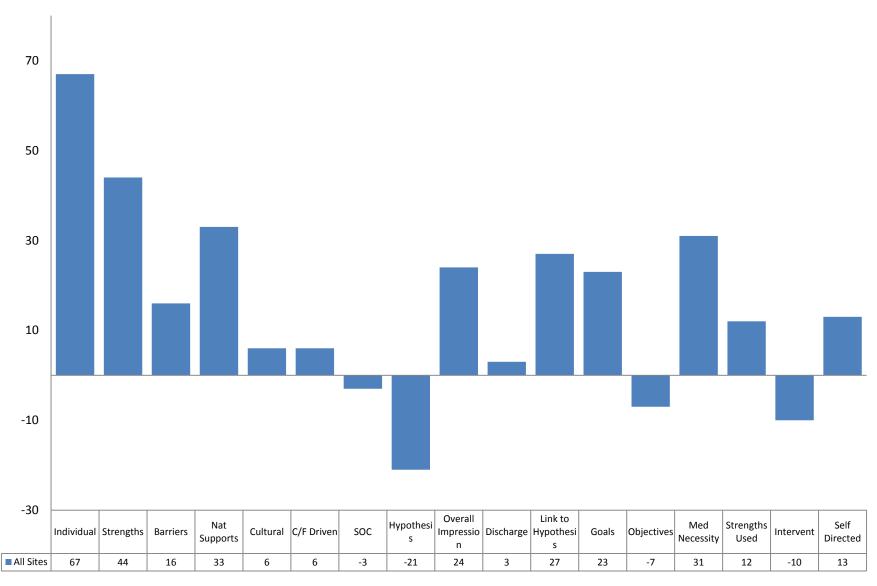
Areas for hypothesis improvement included: stating it clearly; offering clinical impression; describing the precipitating event and impact of trauma (if applicable); utilizing the hypothesis to inform plan development; and, the need to gain a better understanding of the individual through continued conversations and recovery meetings.

Regarding objectives, consultants encouraged sites to write objectives that are SMART (specific, measureable, attainable, relevant, and time-framed). Staff tended to struggle most with specific and measurable criteria. Additional areas for objective improvement include linking more clearly to other plan elements (goal, barriers, medical necessity, narrative, etc.); including too many or too few; and confusion between objectives and interventions, such that objectives often identified service participation (the intervention) as an objective, rather than behavior change or skill development.

A theme that emerged with regard to interventions was the use of "canned," rather than individually-tailored interventions, most often due to the structure of the electronic health record. Most sites improved individualized interventions over the course of the project, particularly when the electronic health record had been modified to allow this. Other suggestions regarding the interventions included: incorporating strengths in the interventions to develop a more personalized, strengths-based plan; utilizing more self-directed, natural, and peer support interventions; and providing interventions to address trauma and substance use issues. Overall qualitative data from the plan-based TA calls suggest that staff tend to struggle with more complex cases (e.g., mental health and substance use disorders, trauma, IDD). These issues were often identified in the narrative, but not addressed in the plan. Teams often had a richer understanding of the individual by the end of the call, which should be capitalized on to improve the narrative and plan.

Figure 8

Total scores across sites on narrative summary and recovery plan elements



When examining total scores on the narrative summary and recovery plan averaged across site over the course of the project, sites demonstrated an overall increase indicating improvements in personcentered documentation skills at the practitioner level (

Figure 9). When comparing the documentation score trendlines in FY2012 (Figure 10) to FY2013 (Figure 9), it is evident that organizations are beginning the project with stronger documentation skills (average of -3.44 in FY2012 vs. -1.14 in FY2013) and are demonstrating greater improvements across time (improving at a rate of 0.99 points/month in FY2012 vs. 1.03 points/month in FY2013). If this trend continues, it is expected that practitioner documentation skills will continue to improve as sites progress further along in the implementation process.

Figure 9

FY2013: Average documentation scores on narrative summary and recovery plan across time

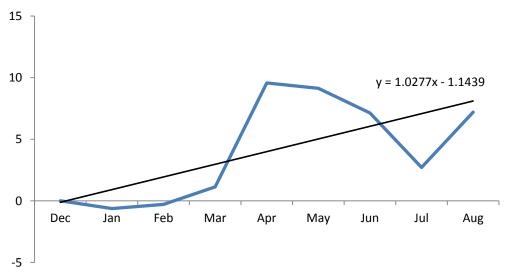
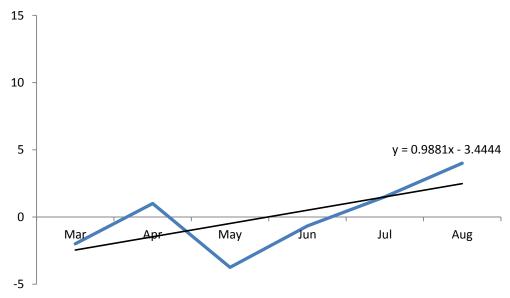


Figure 10 FY2012: Average documentation scores on narrative summary and recovery plan across time



The consultant and coordinator feedback survey findings indicate that overall site documentation is

relatively high compared to other PCRP domains, with a score of 6.13 out of 10 (Figure 6) and rating it the 4th highest of the domains. Further examination of ratings reveals that the two sites that participated in PCRP in FY2012 received higher scores on the consultant and coordinator survey compared to the sites that began participation in FY2013. This finding aligns with the trend

Practitioners continue to show improvement in PCRP documentation and improve at faster rates in the second year of implementation.

of improved documentation scores discussed above, which suggests that practitioners continue to show improvements even after 2 years and, in fact, improve at faster rates in the second year.

Documentation Confidence among Staff. While staff ratings of confidence in writing the recovery plan are higher than the consultant and coordinator rankings of documentation, the reported relative strengths and areas for improvement aligned with findings from the TA Summary Forms. Staff received the lowest scores on and reported lowest confidence writing the hypothesis, objectives and interventions; on the high end of the spectrum for TA Summary Form and staff confidence ratings were strengths and goals (Table 2). Staff report awareness of the areas they could improve and appear to welcome additional support or more training and consultation in these areas.

Table 2
Staff Confidence in Writing the Recovery Plan

Plan Element	Confidence Rating*			
Narrative Summary	7.44			
Hypothesis	7.09			
Strengths and Weaknesses	8.47			
Goals	8.32			
Objectives	7.56			
Interventions	7.94			
Discharge Criteria	7.00			

^{*(1 =} not at all confident to 10 = very confident)

Narrative Summary and Recovery Plan Reviews. At the end of the project period, evaluators requested that each site provide a limited sample of narrative summaries and recovery plans for an external consultant to review. This review included plans from sites participating in FY2012 and FY2013. Sites provided plans that were developed before staff received PCRP training (T1: 9 locations), plans developed approximately 6 months after receiving training (T2: 9 locations), and plans written approximately one year after training (T3: 2 locations that participated in FY2012). The consultant utilized both the DSHS Person-Centered Recovery Planning (PCRP) Quality Improvement Review Tool (Appendix B) and the TA Call Summary Form to evaluate the plans.

Using the DSHS PCRP Quality Improvement Review Tool, average scores of individual tool items (Table 3) increased on every item from the pre-training plans to the 6 month post-training plans, with one exception on item 9 (cultural issues). While the scores increased or remained stable on 7 items (see Table 3) from the 6 month to 1 year post-training plans, scores on 14 items decreased (see Table 3). Change in individual items is more important in a quality review than a total score, but the calculated total score ranged from -11 to 40 with an overall average of 12.9 (SD=6.7, n=31). Sites improved on the quality of documentation after receiving training (T2), with an average overall score of 25.1 (SD =7.3, n=36). For the two units with T3 plans, these documentation scores decreased slightly (M=21.9, SD=6.9, n=10). Plan reviews using the TA Call Summary Form (see Table 4) revealed a similar score pattern as the DSHS PCRP Quality Improvement Review Tool, with total plan scores increasing from T1 (M=-14.1,

SD=7.0) to T2 (M=1.2, SD=14.4) and decreasing from T2 to T3 (M=-8.3, SD=12.2). Likewise, most of the scores on the individual narrative summary and plan content items increased from T1 to T2 and decreased from T2 to T3. These findings highlight the importance of establishing onsite processes for ongoing training, coaching, and quality review to maintain skills. This is particularly important given the high rate of staff turnover typical in this field (and observed at sites participating in this initiative).

Leadership Call Notes on Performance Assessment. On several of the leadership calls, evaluators and consultants indicated that recovery plans have improved over time. However, sites should to begin to establish infrastructure and capacity to evaluate staff performance in the process and documentation of recovery plans, rather than relying solely on the TA Call Summary Forms completed by the evaluators. The project consultants, coordinators, and evaluators more often brought up the issue of quality assessment than did sites, possibly indicating lower priority from a leadership perspective. The use of the DSHS QM Tool as a means to assess plan quality often arose on the calls and this tool is in the process of being finalized. As the sites become more comfortable applying this tool to their plans, they will likely use it more frequently to assess plan quality. The importance of supervision as a means to evaluate staff performance was also a topic often raised by consultants on the leadership calls.

Table 3
All Sites Plan Review Scores using the DSHS PCRP Quality Improvement Tool

Itam			ent To		T1 to T2	T2 to T3
item No.	Item	T1	T2	Т3	N=67	N=10
1	The Recovery Plan includes a description of the recovery goals and objectives based upon the assessment, and expected outcomes of the plan.	.9	.9	1.0	Increase	Increase
2	At least one of the goals statements reflects a meaningful life role/recovery goal or the pursuit of a valued activity outside of the mental health system.	.1	.3	.2	Increase	Decrease
3	The Recovery Plan goals are written in the individuals own words.	9	.4	.4	Increase	Same
4	The Recovery Plan includes a description of the presenting problem/barriers to goal attainment as a result of the mental health or substance abuse issues.	1.5	1.9	2.0	Increase	Increase
	The Recovery Plan includes the expected date by which the recovery goals, objectives, and interventions will be achieved.	2.5	2.7	2.7	Increase	Same
6	The target dates for the objectives in the Recovery Plan vary (if relevant).	.6	1.9	1.6	Increase	Decrease
7	The Recovery Plan includes a description of the individual's strengths.	.7	.9	1.0	Increase	Increase
8	The individual's strengths are actively used in the Recovery Plan rather than just identified in the strengths field.	9	1	6	Increase	Decrease
9	If cultural issues are identified in the assessment, they are addressed in the Recovery Plan unless a clear rationale is provided for deferring issues from the Recovery Plan.	1.0	.0	.0	Decrease	Same
10	If physical health issues are identified in the assessment, they are addressed in the Recovery Plan unless a clear rationale is provided for deferring issues from the Recovery Plan.	.5	.5	.0	Same	Decrease
	If co-occurring substance use is identified in the assessment, it is addressed in the Recovery Plan unless a clear rationale is provided for deferring issues from the Recovery Plan.	.1	.6	1.0	Increase	Increase
12	If trauma issues are identified in the assessment, they are addressed in the Recovery Plan unless a clear rationale is provided for deferring issues from the Recovery Plan.	-1.0	3	-1.0	Increase	Decrease
13	The objective(s) can be linked back to barriers and issues identified in the comprehensive assessment.	1.9	2.4	2.9	Increase	Increase
14	The objectives are expressed in overt, observable actions of the individual. The objectives are written to address observable changes in behavior, functioning or skills that foster the individual's ability to achieve their goals.	1.4	2.4	2.3	Increase	Decrease
15	The objectives are measurable.	1.8	2.5	1.9	Increase	Decrease
	The objectives are attainable and realistic and are based on the individual's current functioning and stage of change.	1.3	2.6	1.6	Increase	Decrease
1/	The interventions specify the frequency, number of units, duration, staff member responsible, and type of services to be provided.	1.5	2.2	1.6	Increase	Decrease
	The interventions specify the purpose/intent as it relates to the Recovery Plan goals and objectives.	1.2	2.4	2.2	Increase	Decrease
ıu	The Recovery Plan incorporates actions/contributions by natural supports (friends, family, peers, and community).	7	4	6	Increase	Decrease
<i>/</i> 111	Interventions include self-directed action steps based on the individuals strengths and identified interests.	9	.1	.0	Increase	Decrease
21	There is a description of the individual's participation in the recovery planning process and evidence that the plan was completed in consultation with the individual. This may be evidenced by quotes, documentation of input, and/or signature(s) from the person receiving services and/or LAR.	.8	1.4	1.3	Increase	Decrease
	Sum of items	12.9	25.1	21.9	Increase	Decrease

Table 4
All Sites Plan Review Scores using the TA Call Summary Form

Item	T1	Т2	Т3	T1 to T2 N=67	T2 to T3 N=10
Narrative Summary					
Individualized	-0.7	1.3	0.0	Increase	Decrease
Strengths	-0.8	0.2	-0.3	Increase	Decrease
Barriers/Functional Impairments	-0.4	0.7	-0.5	Increase	Decrease
Natural Supports	-0.9	-0.1	-0.8	Increase	Decrease
Cultural Factors	0.0	0.0	0.0	Same	Increase
Client/Family Driven	-1.9	-0.5	-1.6	Increase	Decrease
Stage of Change	-1.0	0.2	-1.1	Increase	Decrease
Hypothesis	-1.1	-1.1	-1.6	Same	Decrease
Overall Impression	-0.1	0.5	0.3	Increase	Decrease
Discharge Criteria (Hospital Only)	-1.1	0.5	-0.6	Increase	Decrease
Plan Content					
Plan Content Linked to Hypothesis	-0.2	-0.5	-1.0	Decrease	Decrease
Goals	-1.8	0.2	-0.1	Increase	Decrease
Objectives	-1.6	-0.3	-1.0	Increase	Decrease
Medical Necessity	0.2	0.5	0.7	Increase	Increase
Identified Strengths from Assessment Actively Used	-1.8	0.4	-0.4	Increase	Decrease
Interventions	-1.5	0.0	-0.4	Increase	Decrease
Self-directed and Natural Support Action	-1.9	-0.5	-1.5	Increase	Decrease
Sum of items	12.9	25.1	21.9	Increase	Decrease

Organization Drivers

Organization drivers aim to support the infrastructure of the organization where the program will be implemented. This set of mechanisms aim to create cultivating and hospitable organizational and systems environments necessary to fully implement a program into standard business practices and support the long term sustainability of the new practice. Organizational implementation drivers include decision-support data systems, facilitative administrative supports, and systems interventions.

Decision-Support Data Systems

Both process and outcome data should be monitored and reported on regularly and frequently to move the organization toward continuous improvement. Data systems can inform organizational policy and practice decisions and therefore, should be reliable, accessible, and built into standard business processes (NIRN, n.d.; Fixsen et al., 2005; Metz & Bartley, 2012). Feedback loops should be established such that staff performance evaluations inform changes to be made within the data systems and data systems are adjusted to improve organizational effectiveness and efficiency. Best practices of decision-support data systems include (Fixsen et al., 2013):

Designation of lead person to be held accountable for measurement and reporting system

- Inclusion of intermediate and long-term outcomes in data system
- Inclusion of performance assessment results for all practitioners
- Inclusion of measures that are considered "socially important"
- Data are reliable, reported frequently, built into practice routines, widely shared across the organization, shared with stakeholders, and inform decision-making

Challenges with the electronic health record (EHR) system (Anasazi at the 3 community sites and CWS at the hospital site), continued to come up over the course of the year. Although the community centers all use Anasazi, each system is customized, so there is little standardization across sites. One of the top 4 barriers to implementing PCRP reported by staff at both Time 1 and 2 was that the "planning forms do not have the right fields" (Figure 7). Despite this, sites made progress updating EHRs to better support PCRP, with consultants and coordinator rating these improvements (m=6.25 out of 10) second only to overall site engagement. To enhance this implementation driver, sites should consider including staff performance assessment data in the system as this is considered a best practice. Further, PCRP data entered into the EHRs should be analyzed and reported regularly to stakeholders. The establishment of feedback and feed forward processes could inform changes in staff selection, training, and coaching processes leading to improved staff performance and could also provide leadership with data to make informed decisions to organizational policies and structure.

Leadership Call Notes on Decision-Support Data Systems. Issues with EHRs varied by site, as indicated in the leadership call notes. One site struggled with incorporating elements of the safety plan into the person-centered recovery plan. Towards the end of the fiscal year, this site had success rolling out an updated EHR organization-wide that aligns with person-centered recovery elements. Another site expressed much frustration with the limitations and cumbersome nature of their Anasazi system and made changes to improve some aspects of the systems during the year but other improvements are still being reviewed by internal committees. Sites also seem concerned that changes would affect billing or ability to pass external audit, highlighting an area for DSHS to provide guidance and clarity. Other sites expressed difficulty transferring individual recovery plans from the hospital to the community or from one service package to another; the recovery plan was essentially "lost" when clients progressed to a less intensive service, as the service packages were not linked in the EHR or the different EHRs were not able to communicate electronically with each other. A site also voiced concern with redundancy and "cluttered" feel of the form, opting to hand write treatment plans and scan them into the system during the project. On a recent call, this leadership team reported that a new planning template better aligned with PCRP principles was being finalized and would be rolled out to staff.

Cross-site collaboration on EHR issues is a suitable area for immediate action, as sites often inquired about how other sites were overcoming EHR and data system-related barriers. While sites demonstrated progress, they may benefit from lessons learned and collaboration with other sites.

Facilitative Administrative Supports

Administration can serve as allies or adversaries in the implementation of a new program. The organization must strive to reduce or eliminate implementation barriers and provide a nurturing environment that facilitates practitioner skills development. They serve as decision- and policy- makers at the organization and as the responsible party for the program outcomes, positive or negative. Leadership must be committed and involved in the process through clear communication and feedback loops. Best practices for facilitative administrative supports include (Fixsen et al., 2013):

• Formation of leadership and implementation team

- Development of leadership and implementation team Terms of Reference to establish communication protocols and feedback loops to higher level administrators (practice to policy communication)
- Development or revision of policies and procedures that support new practice
- Use of feedback and data by leadership and implementation team to improve other implementation drivers; solicitation and analysis of staff and stakeholder feedback; removal of administrative barriers

Via Hope requires all sites participating in the initiative form a leadership and change (implementation) team, achieving the first best practice within this implementation driver. The leadership team participates in phone calls with Via Hope staff, consultants, and evaluators on a regular basis to troubleshoot problems and provide an update on PCRP progress. Two sites have gone one step further and established person-centered committees and meetings to further PCRP implementation. To provide these groups with feedback on site person-centered practices, the 32-item Person-Centered Care Questionnaire (PCCQ; Tondora & Miller, 2009) was administered to staff and clients at the beginning and end of the project year. Results of the Time 1 staff and client surveys were shared with the Via Hope facilitators, consultants and site leadership team to provide information on strengths and improvements and to guide Via Hope provided training and technical assistance during the initiative.

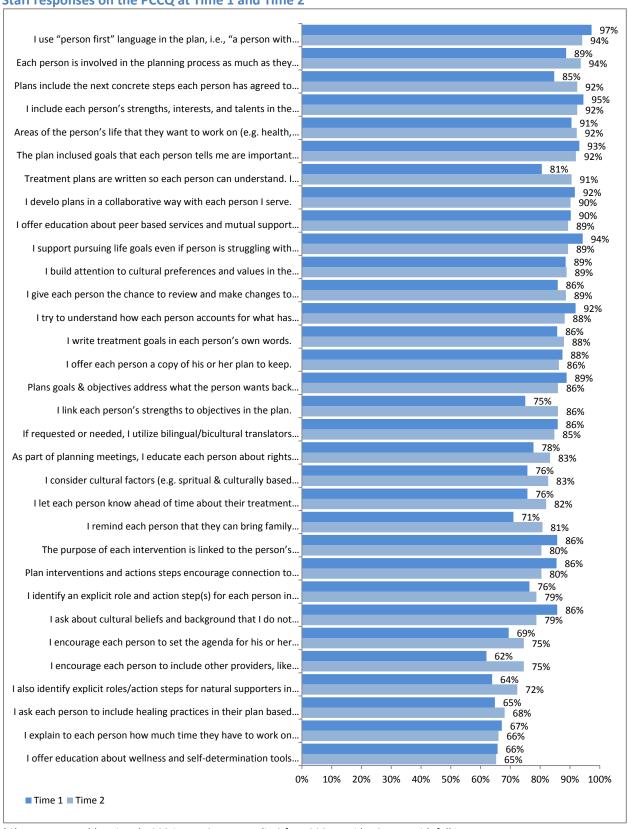
Provider Results - Person-Centered Care Questionnaire (PCCQ). Findings from staff surveys indicate the greatest improvements in the following areas from Time 1 to Time 2 (Figure 11): I remind each person that she or he can bring family members or friends to treatment planning meetings (+10%); Treatment plans are written so that each person and his or her family members can understand them (+10%); I encourage each person to include other providers, like vocational or housing specialists, in their

meetings (+13%); and I link each person's strengths to objectives in his or her plan (+11%). The largest decreases from Time 1 to Time 2 occurred in the following areas: The interventions and action steps identified in the plan encourage the person's connection to integrated/natural settings and supporters (rather than segregated settings designed only for people with mental illness) (-5%); I ask

Support for and concerns about PCRP from the staff perspective included comments such as "... we are all in support of this method of treatment planning. However, the computer programs, forms and time constraints/caseload required by our agency make it very difficult and frustrating to actually implement with clients" and "Seeing [the] client identify and work towards their achievable goals."

about cultural beliefs and areas of each person's cultural background that I do not understand to enhance the cultural relevance of the planning process (-7%); I support people in pursuing goals such as housing or employment, even if they are still struggling actively with medication adherence, sobriety, or clinical symptoms (-5%); I identify the purpose of each intervention in the plan to link it to the person's identified goals and objectives (-5%).

Figure 11
Staff responses on the PCCQ at Time 1 and Time 2



^{*}Chart presents abbreviated PCCQ items. See Appendix C for PCCQ-Provider Survey with full items.

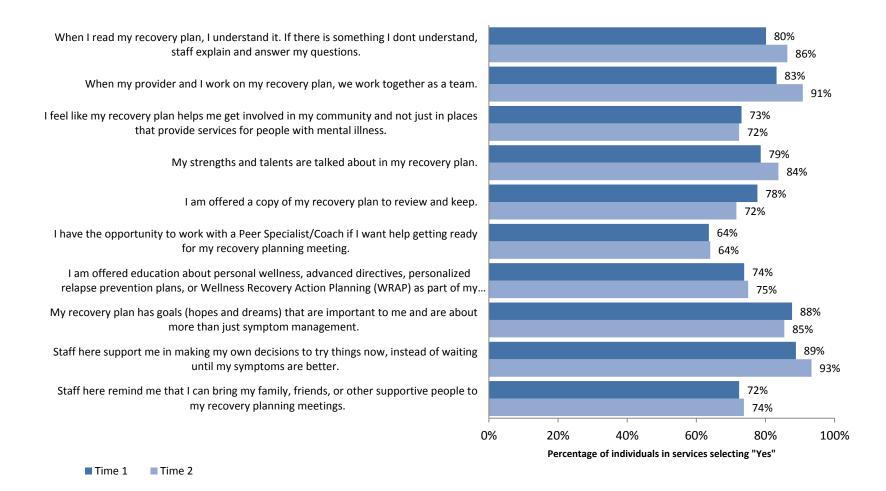
Person in Recovery Results - Person-Centered Care Questionnaire (PCCQ). The PCCQ-PIR (Tondora & Miller, 2009) is a 32-item modified version of the provider PCCQ survey to assess person-centered practices occurring at the organization from the client perspective. Based on feedback from the sites, the evaluation team reduced the PCCQ to 10- items with input from consultants and changed the response scale from a 5-point Likert ranging from strongly disagree to strongly agree to a Yes/No/I don't know response scale. The revised instrument was administered at Time 1 and Time 2. Findings indicate the greatest improvements across time in the following areas (Figure 12): When my provider and I work

on my recovery plan, we work together as a team (+8%); When I read my recovery plan, I understand it. If there is something I don't understand, staff explain and answer my questions (+6%); My strengths and talents are talked about in my recovery plan (+5%); and

The best part of PCRP from the client perspective included comments such as ... "Getting goals set up and a plan in place for getting them realistically met" and "...having a roadmap" and "a goal of seeing my kids"

Staff here support me in making my own decision to try things now, instead of waiting until my symptoms are better (+5%). Only 3 areas demonstrated a decrease over time: I am offered a copy of my recovery plan to review and keep (-6%); My recovery plan has goals (hopes and dreams) that are important to me and are about more than just symptom management (-2%); and I feel like my recovery plan helps me get involved in my community and not just in places that provide services for people with mental illness (-1%).

Figure 12
Client responses on the PCCQ at Time 1 and Time 2



Comparing Person in Recovery and Provider PCCQ Time 2 Responses. Comparing similar PCCQ items offers information on how aligned clients and staff are in their perceptions of the organization's personcentered practices, and can be used to assess improvement over time. Table 5 presents a comparison of staff and client agreement with 10 person centered practice items, although the items are not worded exactly the same. Both staff and clients report generally high use of person-centered practices (no

practices with less than 64% agreement). Overall, staff report higher use of person centered practices than clients report receiving them, except for higher client report of working on their recovery plan as a team with their provider (91% agreement), which is essential to PCRP

Ways to improve PCRP from the client perspective included comments such as "get [me] involved with peer groups, socialize with the public through volunteer or community groups" and "positive thinking outside of the box!"

practice. The items with the largest gaps between provider and client response are in offering peer support (89% versus 64% agreement) and offering a copy of the plan for the individual to keep (86% versus 74% agreement).

Table 5.

Time 2 Provider and Person in Recovery PCCQ Response Comparison

	Staff*	Clients*	
Staff PCCQ Items	Time 2	Time 2	Client PCCQ Items
I include in treatment plans the goals that each person tells me are important to them.	92%	85%	My recovery plan has goals (hopes and dreams) that are important to me and are about more than just symptom management.
I support people in pursuing goals such as housing or employment, even if they are still struggling actively with medication adherence, sobriety, or clinical symptoms.	89%	93%	Staff support me in making my own decisions to try new things now, instead of waiting until my symptoms are better.
I remind each person that she or he can bring family members or friends to treatment planning meetings.	81%	74%	Staff here remind me that I can bring my family, friends, or other supportive people to my recovery planning meetings.
I offer each person a copy of his or her plan to keep.	86%	72%	I am offered a copy of my recovery plan to review and keep.
Treatment plans are written so that each person and his or her family members can understand them. When professional language is necessary, I explain it.	91%	86%	When I read my recovery plan, I understand it. If there is something I don't understand, staff explain and answer my questions.
I include each person's strengths, interests, and talents in his or her plan.	92%	84%	My strengths and talents are talked about in my recovery plan.
I develop care plans in a collaborative way with each person I serve.	90%	91%	When my provider and I work on my recovery plan, we work together as a team.
The interventions and action steps in the plan encourage the person's connection to integrated/ natural settings and supporters (rather than segregated settings only for people with mental illness).	80%	72%	I feel like my recovery plan helps me get involved in my community and not just in places that provide services for people with mental illness.
I offer education about personal wellness and self-determination tools such as WRAP and advance directives as part of the planning process.	65%	75%	I am offered education about personal wellness, advanced directives, personalized relapse prevention plans, or WRAP as part of my recovery planning meeting.
I offer education about peer based services and mutual support groups as part of the planning process.	89%	64%	I have the opportunity to work with a Peer Specialist/Coach if I want help getting ready for my recovery planning meeting.

^{*}Staff = % reporting strongly agree or agree with item; Client = % reporting yes to item.

Leadership Call Notes on Facilitative Administration. On individual site leadership calls, the evaluation team presented data from the Time 1 surveys and sites expressed agreement with the findings. The leadership team also noted a diffusion of principles when staff working on a unit that was participating in PCRP began working on a unit not participating in PCRP, potentially indicating an organizational culture more supportive of recovery and person-centered practices. Some units or staff within the organizations were cited as having a culture in which person-centered care principles are not readily fostered and accepted. Sites did notice a shift to less resistance over time. One of the main barriers to implementing PCRP, which was indicated on both the staff survey and on leadership calls, was the amount of time spent on the entire process, leading to less belief that PCRP sustainability is feasible. Communication around this issue is needed to remove some PCRP resistance; particularly that the process might take longer initially, but as staff become more skilled and clients engage in a process that is authentically about their life goals, time spent will be reduced and client outcomes will improve. Other than time and organizational culture, other barriers indicated include resources for training and needed EHR changes, high caseloads, and staff turnover.

Systems Interventions

Developing collaborative relationships between participating organizations, program implementers, and external systems is imperative to the future of the program. The availability of financial, organizational, and human resources are required to support the work at the individual practice level. Person-centered care could be immensely impactful if implemented in a way that lays the foundation for other programs aimed to achieve recovery and resilience for all. Best practices for systems interventions include (Fixsen et al., 2013):

- Resolution of system issues by leadership (e.g., issues at the state level that interfere with effectiveness)
- Engagement of leaders and champions outside of the organization
- Documenting and reporting barriers to higher level administrators
- Providing recommendations to resolve barriers to higher level administrators
- Establishment of formal processes to utilize practice to policy communication loops
- Creation of time-limited, barrier resolution capacity through use of Transformation Zones and usability testing
- Creation of optimistic and hopeful organization culture through regular success story communication

In Texas, DSHS must not only be aware of the PCRP program for it to be effective, but must also support implementation by establishing policies complementary to person-centered care and understanding how PCRP can link and support the effectiveness of DSHS-MHSA and state initiatives. With the DSHS-MHSA vision of "Hope, Resilience, and Recovery for Everyone," person-centered and recovery-oriented care represents a fundamental process and practice vehicle for all services overseen by the division. DSHS now mandates the use of a strength and needs based assessment (the ANSA: Adult Needs and Strengths Assessment, cite) to determine level of care placement. DSHS-MHSA also requires evidence-based and promising practices as interventions, including evidence-based interventions such as Illness Management and Recovery, Seeking Safety, and Cognitive Behavioral Therapy. Additionally, client outcomes are recovery focused and linked to provider incentive payments. As described in the introduction, PCRP serves as an umbrella to link the assessment, best practices, and outcomes and is aligned with federal programs that aim to make person centered practice the center of all health care to drive quality and outcomes, and subsequently, reduce costs. Data from site staff surveys indicates that sites feel that PCRP is an "add-on" project that will improve their client care and staff competency, but is not an immediate priority or supported at the state level. UT-TIEMH evaluators, Via Hope consultants

and coordinators have recommended more consistent messaging on PCRP through the incorporation of person-centered language in contracts and in interpretative documents, such as billing guidelines for psychosocial rehabilitation services that support PCRP.

Trauma Informed Care, Trauma Specific Interventions, and Substance Use Disorder Treatment. The recovery plans reviewed during the plan TA coaching calls were reviewed by evaluators at the end of the project period. Plans revealed a significant number of individuals who were working on their mental health recovery and doing so with unresolved issues related to trauma and substance use. Of 42 plans reviewed across four clinics of three participating centers, 59.5% revealed individuals in need of trauma treatment and 42.9% in need of substance use treatment services. Of 21 plans reviewed across two units of the hospital, 47.6% revealed individuals in need of trauma treatment and 23.8% in need of substance use treatment services. At the beginning of the initiative, center sites indicated that there were few providers qualified to provide treatment for trauma and of those that were, it was difficult to get on their schedules or to access the service in rural areas. A focus by DSHS on trauma informed care, inclusion of trauma assessment in the ANSA, and the availability of training in Cognitive Processing Therapy and Seeking Safety – evidenced based trauma treatments, increased the focus on trauma and the number of providers available to provide trauma treatment by the end of the project period. Centers still indicate a need to become more attuned to trauma informed care and to increase access

and availability of evidenced-based trauma treatment. Although the hospital has been very involved in state level initiatives to increase trauma informed care (e.g. seclusion and restraint reduction) staff reported that providing interventions to address trauma were not within their purview, and were not reasonable or feasible given resources, length of stay, and that these

Data from coaching calls revealed that 59.5% of 42 Center and 47.6% of 21 Hospital individual's recovery plans had mental health barriers related to unresolved trauma.

issues were better addressed in the community. To effectively address the needs of individuals in the public mental health system, and achieve improvements in the DSHS measure of community tenure, it will be important for the system to continue stressing the importance of trauma informed care and trauma specific treatment. Person centered recovery planning supports these efforts.

Leadership Call Notes on Systems Interventions. The participating hospital found the lack of continuity of care a system-wide barrier to be addressed. When individuals are discharged from a person-centered hospital environment, they often find themselves receiving services from community settings that are not person-centered and have more rigid treatment planning approaches. This site called for DSHS to develop the infrastructure that will allow for a smoother transition from the hospital to the community setting. The participating sites' leadership teams also frequently questioned how PCRP relates to other DSHS and other statewide initiatives. From the site-level perspective, the policies and initiatives seem disjointed and they requested communication around this issue to bring everything together cohesively. The questions around the use of the DSHS QM tool were also apparent on several leadership and state workgroup calls. Overall, sites are seeking clarity around and communication about PCRP implementation.

Leadership Drivers

Leadership is critical to the establishment and sustainability of effective programs as they are responsible for making decisions, providing guidance, and supporting staff and organizational functioning. Two leadership styles, adaptive and technical, are imperative at different points of program development and implementation. While adaptive leadership might be most important early in the process, when the implementation of the practice requires organizational transformation, technical

leadership may be more important later on in the process once a program has been successfully implemented and the focus is now on program maintenance and sustainability. However, the relationship between adaptive leadership and technical leadership must not be undermined, both are incredibly important to the successful implementation and sustainability of a program. Leadership may simply be one individual, but is often a group of individuals at different levels and with varying responsibilities within the organization. Certain leaders and leadership teams may possess both types of leadership styles.

Consultants and coordinators rating of leadership commitment and involvement varied by site, with

average scores ranging from as low as 2.75 to as high as 8.50 on a 1 to 10 point scale. Overall, leadership commitment received the highest average rating out of the PCRP domains (m=6.31 out of 10; Figure 6). Leadership is perceived to be more committed to PCRP than they are

Coordinator and consultant rating of leadership varied by site, with PCRP leader commitment (M = 6.31) receiving a higher rating than leader involvement (M = 5.44).

involved (m=5.44 out of 10). This finding is true across all four sites, from the consultant/coordinator perspective.

Adaptive Leadership

Adaptive leaders are important in the beginning stages of implementation when decisions are being made about the initial implementation of the program, when stakeholders are more likely to hold conflicting opinions when it comes to programmatic decisions. Adaptive leaders often must confront current organizational values in order to facilitate change. To do be effective, they must be able to convince stakeholders why the change is imperative to the future of the organization. Organizations may be resistant to change if they must change their values, norms, and practices, particularly if they don't see any long-term advantages to making the change. When the aim is to change the system, the salience of adaptive leadership skills cannot be ignored. In understanding the difference between leadership and authority, those possessing adaptive skills are more often thought of as leaders, while those possessing technical skills are thought of as individuals in a position of authority that provide direction and order. Best practices for adaptive leadership include (Fixsen et al., 2013):

- Continual alignment of new practice with organizational mission, values and philosophies
- Consensus building when little agreement exists amongst stakeholders related to moving forward
- Establishment of communication loops that serve to provide information to practitioners and receive feedback on benefits and concerns
- Actively and routinely seeking feedback from practitioners and other stakeholders related to the intervention
- Active involvement in employment interviews, practitioner training, and staff and organizational performance assessments to inform decision making

Because the organizations participating in PCRP are in the process of adopting a practice that is radically different than standard business practices, adaptive leadership is immensely important at this time.

Leadership Call Notes on Adaptive Leadership. During FY2013, sites demonstrated more adaptive leadership than technical leadership. Sites established committees and workgroups to facilitate PCRP implementation, worked on establishing communication loops with the participating units (although not necessarily agency-wide communication loops), developed supervision action plans and project plans, brainstormed processes to implement PCRP at their particular organization, and developed tools and protocols to facilitate implementation. At this point in the implementation process, the adaptive

leadership drivers must be extremely strong in order for full implementation and eventual sustainability to occur. Two of the best practice areas that sites could use some assistance is having leadership take a more active role in soliciting feedback from stakeholders and being more active in the interview, training, and staff performance assessment process to inform organizational decision-making.

Technical Leadership

A person possessing technical leadership qualities is someone who is a good manager. They are engaged and able to respond quickly and effectively to issues that may arise. Technical leaders work most effectively when a clearly defined end result exists and possess the problem-solving skills to reach it, particularly when there is a known resolution and there is high stakeholder agreement related to the end result. This leadership quality is perhaps more important once the program has established some stability within an organization and the aim has moved from program implementation to program sustainability. Best practices for adaptive leadership include (Fixsen et al., 2013):

- Provision of guidance on technical issues when clarity exists on what needs to be accomplished
- Provision of reasons for policy, procedure, or staffing changes
- Engaged in barrier resolution related to practice implementation
- Focus on issues that impact effectiveness at the practice level
- Demonstrate fairness, respect, consideration, and inclusiveness with staff and other stakeholders

Leadership Call Notes on Technical Leadership. Overall, most of the site-level technical leadership evident on the leadership calls related to the coordination of on-site technical assistance and trainings. As the sites are currently in the early phases of PCRP implementation, the majority of technical assistance demonstrated on the project is provided by Via Hope project coordinators and the consultants. Leaders are currently unsure of what the end product of PCRP implementation will look like as this practice is relatively new in the organization; understanding the intended outcome is imperative for technical leadership. Some of the leadership teams are beginning to think about how the sustain PCRP in the long run and technical leadership will need to come into play as policies and procedures are modified to make PCRP a standard business practice. One area in which site-level technical leadership was beginning to shine was in accomplishing tasks laid out in a project plan. In the upcoming year, Via Hope will emphasize the use of the project plan on the leadership calls.

Effective PCRP Strategies

Implementation fidelity refers to the degree to which programs are carried out as intended. Because PCRP has not been established as an evidence-based practice, fidelity with which Via Hope is implementing this program in Texas cannot currently be assessed. Best practices with regard to implementation have been outlined in this report, but were not developed specifically for PCRP in Texas. However, as the program continues to develop and evaluators collect client-level outcomes, the evaluation team can use the implementation best practice framework to examine particular strategies that hinder or are effective in establishing and sustaining PCRP within organizations and improve client outcomes. As more is learned about effective PCRP strategies, more rigorous studies can be conducted to contribute to the PCRP evidence base.

Client Outcomes

A program must be both well-implemented and effective in order to achieve desirable outcomes. Similar to the limitations of being able to determine effective PCRP strategies, evaluators did not directly assess client level outcomes this fiscal year due to the infancy of the PCRP initiative and focus on assessing quality of documentation. Preliminary findings on the client survey indicate an appreciation of the recovery planning process as it allows them to work collaboratively with a team. During the next fiscal year, individual client level outcomes will be assessed. The evaluation team will be collecting measures to assess client's personal recovery and engagement in the recovery process. Recovery measures of clients receiving services at units where PCRP is being implemented will be compared to those of clients receiving services at units in which PCRP has yet to be implemented. If results indicate improved recovery outcomes at the units implementing PCRP, we will have preliminary data to support a more rigorous study of effectiveness.

Conclusions and Recommendations

Selection

Major Findings

Staff selection is the first and, perhaps the most critical step, in the implementation of a program. Program success is often dependent on the knowledge, skills, and abilities of key staff members. Although Via Hope provided guidelines for selecting appropriate team members, sites would benefit from additional support in selecting key members of the change team. Overall, staff members demonstrated a considerable amount of knowledge regarding PCRP principles; however, more rigorous methods should be utilized by evaluators to assess staff knowledge. Staff engagement as measured by attendance and participation on calls appeared to decrease over the course of the project, potentially indicating that the staff believed they no longer needed assistance, did not recognize the value of the assistance, or experienced initiative fatigue. Psychiatrists and peer specialists represent workforces that could be better integrated into the process. With a few exceptions, psychiatrists were unengaged in and, in some cases, resistant to PCRP. Furthermore, sites did not fully capitalize on the skills and experience peer specialists can offer to PCRP, although involvement and participation varied significantly by site. Leadership teams discussed this implementation driver the least frequently on leadership calls, possibly not possessing knowledge or awareness of this pertinent implementation driver.

- Develop staff selection criteria for sites to identify and select appropriate staff members. Include sample competencies and job descriptions for project leads, coaches, trainers, and other staff critical to PCRP success
 - o Make these criteria easily accessible through a PCRP Implementation Toolkit or Manual
 - Identify these criteria as critical components to participation in and success of PCRP
- Consider requiring sites to designate one full time staff member to be responsible and accountable for carrying out key project activities and facilitating implementation progress
- Clarify who should attend training/technical assistance events to ensure appropriate staff members participate (e.g., through a registration process)
- Utilize more rigorous methods for assessing knowledge, skills, and abilities
- Develop better messaging that highlights the value of the program to increase engagement
- Increase efforts to engage and involve psychiatrists, particularly when they are perceived as the leader of the treatment team
- Support sites to more readily integrate peer specialists as key members of the PCRP process

- Discuss staff selection on leadership calls more frequently to highlight the importance of identifying the most appropriate staff for each position involved in the project.
- Utilize data from staff surveys to understand staff knowledge and skills, address implementation barriers and emphasize implementation strengths.

Training

Major Findings

Staff received ample training and technical assistance opportunities over the course of the project. In general, these events were successful and deemed valuable by staff members. Trainings often included a number of different methods including didactic instruction, discussion, practice, and role-plays which align nicely with training best practices. However, feedback surveys were not administered at each training and technical assistance event by evaluators. Furthermore, learning objectives were not identified prior to each event, which would assist evaluators in assessing attainment of intended learning objectives. While Via Hope predominantly provides training to the sites, to ensure long-term practice sustainability, future efforts should include assisting sites to develop internal trainers and training programs. Some training felt siloed, particularly the peer specialist training. To fully integrate peers into the PCRP process, key leadership and non-peers should participate in at least a portion of the peer specialist training as a means to gain insight into potential PCRP roles, such as the identification of recovery goals or developing skills to get in the driver's seat of the recovery planning process. Finally, much discussion on site leadership calls pertained to logistics (date, time, place, and agenda) with less emphasis on agenda development and training relevance.

Recommendations

- Set clear expectations by identify learning objectives prior to each event and providing to sites in advance of the training event
- Administer standard feedback survey across all training and technical assistance events to compare training value, satisfaction of participants, and achievement of learning objectives
- Assist sites in cultivating trainers to facilitate long-term sustainability of PCRP practices
- Utilize data collected at training events to inform selection and recruitment procedures as well as ongoing coaching practices and needs
- Incorporate non-peer staff and leadership into PS training

Coaching

Major Findings

To continue skill development after training, consultants coached sites on the documentation and process of PCRP on bi-monthly coaching calls. Because this practice is so new, the majority of staff members needed time to develop PCRP skills before being able to coach other staff members on plan development. After the supervisor training in April, PCRP leaders at the sites began coaching their teams on calls, with support provided by the consultants. Developing coaches within the organizations is critical to sustainability. The plan-based TA calls, where coaching primarily took place, was seen as highly valuable to the sites. Sites varied on their availability and receptivity of coaching feedback and, therefore, feedback provision varied by site, calling for a need to establish standardize feedback procedures. In the next fiscal year, sites will be encouraged to establish co-supervision or consultation groups, which will allow the coaches to get feedback and insight from their peer coaches and troubleshoot potentially difficult situations that may arise. An appreciation for the plan-based TA calls was expressed frequently on the leadership calls as it allowed staff to practice their skills "on-the-job" with actual individuals in services.

Recommendations

- Coaching should be assessed using a standardized process during the plan-based TA calls in addition to assessing quality of documentation
- Sites should designate a lead coach(es) responsible for developing new site coaches and monitoring coaching skills
 - Coaching skills monitoring should utilize a variety of methods including observation,
 record review, feedback from those being coached, and practitioner skill development
- Standardized feedback procedures after TA calls should be established to ensure consistent feedback across sites and ability to assess development of coaching skills
- Coach sites on the PCRP process, in addition to PCRP documentation
- Utilize coaching data to inform other implementation drivers (e.g., selection, training, and performance assessment)

Performance Assessment

Major Findings

Evaluators collected a considerable amount of data related to staff performance assessment. However, sites need to begin to assume some of the performance assessment responsibilities to ensure sustainability of practices. Evaluators will work more closely with site Quality Management in the coming years to help establish assessment procedures into regular business practices. While individuals were scored on documentation quality in this year, these scores were removed before being sent to sites as some staff focused on scores rather than the feedback focusing on improving the quality of the plan. Best practices encourage transparent processes to inform staff on performance, so in future scores should be shared with teams. Overall, sites excelled in creating individualized narrative summaries, identifying natural supports, linking plan to hypothesis, and demonstrating medical necessity. Areas where sites tended to struggle in creating the narrative summary and recovery plan include stage of change, hypothesis, objectives, and interventions which would be expected in the first year of using a new practice. Overall, documentation quality increased across time for all sites indicating an improvement in PCRP skills. Documentation quality increased more rapidly in FY2013 than it did the previous year, indicating a need to provide sites enough time to learn new skills and for those skills to be translated into performance improvements. Further, documentation was rated as one of the higher domains by consultants and coordinators and staff were confident in their documentation abilities. The importance of supervision and assessment tools arose often on leadership calls.

- Monitor documentation scores on regular basis and provide additional support/information (e.g. examples in a toolkit; focus on future calls) on areas of the narrative summary and recovery plan that are consistently receiving lower scores
- Assist sites in the establishing infrastructure and capacity to evaluate staff performance in creating and writing the PCRP
 - Designate an individual, probably staff within Quality Improvement or Quality
 Management, who can be responsible for assessing and reporting progress to staff.
- Reconsider including ratings of narrative summary and plan elements when sending feedback to sites to cultivate a sense of transparency, at least on a quarterly basis
- Evaluators should utilize multiple data sources to evaluate performance
- Use documentation quality data over the course of the project to focus on elements of the plan in which sites require more assistance
- Allow sites ample time (at least two years) for new skill development to translate into improved performance within each unit

 Continue to work with DSHS-MHSA on the development of the PCRP Quality Improvement Tool, outcomes related to PCRP, and policies and programs that support recovery and personcentered practices

Decision Support Data Systems

Major Findings

Sites encountered a number of difficulties with the Anasazi (communities) and CWS (hospital) electronic health record systems, particularly at the beginning of the project. While most of the sites developed work-arounds in order to utilize the system for PCRP documentation, it was initially cited as a major barrier to PCRP on both the plan-based TA and leadership calls. Sites seemed interest in the prospect of having IT staff working together across sites to share lessons learned and strategies in modifying the systems ways that align and support PCRP practices. As sites get more comfortable using the new systems, they should utilize the data collected to inform implementation. The data should be reliable and analyzed regularly to provide timely information for executive leadership to share with staff.

Recommendations

- Provide a cross-site forum for sites to troubleshoot difficulties with electronic health records
- Assist sites in recognition of the importance of PCRP data and how it can be used to inform other areas of the implementation process (e.g., staff performance assessments, coaching data, training data, staff selection data, individual client outcomes and inclusion in their care)
- Establish short, intermediate, and long-term PCRP outcome variables that organizations can examine in their systems

Facilitative Administration

Major Findings

Two of the sites established person-centered committees and regularly scheduled meetings to further PCRP implementation at the site level. While Via Hope knows little about these committees, sites report they are working to identify barriers to implementation and establish an environment that nurtures recovery and person-centered practices. Further, all sites were required to form leadership and implementation teams at the beginning of the project. The effectiveness and engagement of these teams vary by site, but some have been effective in establishing and revising policies and procedures that are supportive of PCRP. Both staff and clients rated sites high on organizational person-centered care practices assessed with the PCCQ. The leadership team also noted a diffusion of principles when staff working on a unit that was participating in PCRP began working on a unit not participating in PCRP, potentially indicating an organizational culture supportive of recovery and person-centered practices. Some, but not all, units and staff within the organizations were cited as having a culture in which person-centered care principles are not readily fostered and accepted. Sites did notice a shift of increased participation, interest in, and less resistance over time.

- Leadership and implementation teams should utilize feedback and data to improve and integrate implementation drivers
- Assist sites in developing a rich understanding of barriers and facilitators to PCRP, including information related to implementation science
- Administrators should solicit and assess staff and stakeholder feedback on an ongoing basis to enhance an organizational recovery environment and reduce potential administrative barriers
- Via Hope should engage more frequently with site committees to reduce duplication of efforts
- Increase communication regarding the amount of time it takes for the PCRP process

Systems Interventions

Major Findings

The flexible support needed to make person-centered planning work may be difficult in large traditional service systems with "all-in one" service packages (Claes et al., 2010). These systems make it difficult to support an individual in selecting their own goals and making their own decisions about the support and services they need to reach the goal. To be able to sustain practices over time, DSHS must establish policies and procedures complementary of person-centered care and make financial resources available. The state should also message about PCRP in a way that identifies its' relationship to other DSHS-MHSA recovery focused and care improvement initiatives.

Recommendations

- Communicate DSHS support and prioritization of PCRP at the state level
- Incentivize participation in the PCRP initiative
- Connect the dots for organizations on how PCRP relates to other DSHS initiatives/programs
- Understand how PCRP can be the foundation for other initiatives/programs intended to support the vision of "Hope, Resilience and Recovery for Everyone"
- Establish regular feedback loops to inform high level administrators of PCRP barriers and facilitators (e.g., continuity of care from hospital to center and vice versa; peer support in PCRP)
- Engage leaders and champions at the state level to spread a consistent PCRP message
- Share program successes to a broad audience to engage stakeholders and develop widespread support

Adaptive Leadership

Major Findings

Adaptive leadership is extremely important at the current early stage of PCRP implementation because this practice is radically different from traditional treatment planning in Texas. Sites must cultivate adaptive leadership skills that can affect organizational culture to ensure implementation is successful. Overall, sites demonstrated a higher degree of adaptive leadership relative to technical leadership on the monthly leadership calls, with leaders making organizational changes needed to support PCRP implementation. Although regular conversations occurred between consultants/coordinators and leadership teams, Via Hope could offer more intentional support that develops site leader skills to implement recovery practices new to the system and their organization.

- Educate sites on the differences between different types of leadership, and the importance of fostering both types of leadership skills in the organization
- Consider ways to offer content and tools used in the Recovery Institute Leadership Academy to PCRP leaders to support implementation.
- Develop tools that help sites identify potential leaders for PCRP implementation, training and coaching
- Continue to review organizational mission, values, and philosophies to maintain alignment with PCRP practices and concepts
- Encourage leaders to establish regular communication feedback loops and to share quantitative and qualitative data with practitioners and other stakeholders
- Site level leaders should be actively involved in developing job descriptions, in interviews, training, and performance assessments in order to make informed decisions

Technical Leadership

Major Findings

Sites demonstrated technical leadership capabilities (PCRP project management) primarily through the coordination of team members and calls. While the program is still in its infancy, it is important to begin thinking about technical leadership as PCRP moves from implementation to diffusion to sustainment. During the next fiscal year, sites must assume more responsibilities for implementing practices to ensure sustainability and to allow Via Hope to begin diffusion of PCRP to other sites across the state. One way to transfer responsibility is by supporting sites to develop, track, and accomplish tasks in the project plan and to provide a "toolkit" with resources to assist with implementation. Some of the leadership teams were beginning to think about how the sustain PCRP by the end of the project and technical leaders will be needed as policies and procedures are modified to make PCRP a standard business practice.

- Educate sites on the differences between and importance of different types of leaders for implementing and sustaining a new practice or program
- Provide tools to support technical leadership in PCRP implementation
- Provide tools that help sites identify and cultivate leaders who demonstrate problem-solving and task-oriented skills
- Assist sites in PCRP barrier identification and resolution

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Appendix ATA Call Summary Form

Texas Person Centered Recovery Plan Implementation Summary of Consultation Call

Date:	Pilot Site:
Form completed by:	Number of staff on call:
Consultants on call:	Name/role of staff on call:
Primary consultant:	Plan completed by:

PLAN REVIEW/CONSULTATION

Was a person and plan discussed:

Plan discussed (initial or first name):

Rating options for the elements and principles of the Person Centered Plan include:

Excellent, Good, Minor Issue, Major Issue, and not applicable for this consultation or plan (n/a)

Areas	of:	Strengths	Improvement	Rating
Formu	lation/Narrative:			
a.	Individualized			
b.	Strengths Identified			
c.	Barriers/Functional Impairment Clear			
d.	Client/Family Driven (hospital only)			
e.	Natural Supports Identified			
f.	Cultural Factors			
g.	Stage of change			
h.	Hypothesis			
i.	Discharge criteria (hospital only)			
j.	Overall impression (LMHA only)			

Plan Content		
Plan Content linked to		
Hypothesis (LMHA only)		
Goals		
Objectives		
Medical Necessity (seen in		
barriers/unique needs as well		
as "linking" of plan elements)		
Identified Strengths from		
Assessment ACTIVELY USED		
(LMHA only)		
Interventions		
Self-directed and Natural		
Support Actions		

Any additional information discussed prior to review of plan?

Was there a peer specialist on the call?
What role did the peer specialist play in plan development?

If any, describe INTERNAL system barriers identified on the call: If any, describe EXTERNAL system barriers identified on the call: Consultant or Site follow-up activities and person(s) responsible:

Appendix B

DSHS Person-Centered Recovery Planning (PCRP) Quality Improvement Review Tool

Instructions: Complete each question by marking your response. If you have comments about the following questions, please use the comment section below. If you answer NA to any of the questions please enter justification in the comment section below.

Date of Review: Name of Individual:

Name of Provider: Local ID Number:

Name of Reviewer: CARE Number:

1. The Recovery Plan includes a description of the recovery goals and objectives based upon the assessment, and expected outcomes of the plan.

Yes No

2. At least one of the goals statements reflects a meaningful life role/recovery goal or the pursuit of a valued activity outside of the mental health system.

Yes No.

3. The Recovery Plan goals are written in the individuals own words.

Yes No

- 4. The Recovery Plan includes a description of the presenting problem/barriers to goal attainment as a result of the mental health or substance abuse issues.
 - 2 = Barriers which directly interfere with life recovery goals are listed and given priority attention in the Recovery Plan
 - 1 = Mental health/substance use related barriers that are listed do not appear directly related to life/recovery goals
 - 0 = The barriers identified are not related to mental health or substance use issues
- 5. The Recovery Plan includes the expected date by which the recovery goals, objectives, and interventions will be achieved.
 - 3 = All of the objectives specify the target date
 - 2 = Most of the objectives specify the target date
 - 1 = Some of the objectives DO NOT specify the target date
 - 0 =None of the objectives specify the target date
 - All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0

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- 6. The target dates for the objectives in the Recovery Plan vary (if relevant).
 - 3 = All of the objectives in the Recovery Plan vary
 - 2 = Most of the objectives in the Recovery Plan vary
 - 1 = Some of the objectives in the Recovery Plan vary
 - 0 =None of the objectives in the Recovery Plan vary
 - All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0
- 7. The Recovery Plan includes a description of the individual's strengths.

Yes No

8. The individual's strengths are actively used in the Recovery Plan rather than just identified in the strengths field.

Yes No

- 9. If cultural issues are identified in the assessment, they are addressed in the Recovery Plan unless a clear rationale is provided for deferring issues from the Recovery Plan. Yes No NA
- 10. If physical health issues are identified in the assessment, they are addressed in the Recovery Plan unless a clear rationale is provided for deferring issues from the Recovery Plan.

Yes No NA

11. If co-occurring substance use is identified in the assessment, it is addressed in the Recovery Plan unless a clear rationale is provided for deferring issues from the Recovery Plan.

Yes No NA

12. If trauma issues are identified in the assessment, they are addressed in the Recovery Plan unless a clear rationale is provided for deferring issues from the Recovery Plan.

Yes No NA

- 13. The objective(s) can be linked back to barriers and issues identified in the comprehensive assessment.
 - 3 = All of the objectives can be linked to barriers/issues identified in the assessment
 - 2 = Most of the objectives can be linked to barriers/issues identified in the assessment
 - 1 = Some of the objectives can be linked to barriers/issues identified in the assessment
 - 0 = None of the objectives can be linked to barriers/issues identified in the assessment

All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0

14. The objectives are expressed in overt, observable actions of the individual. The objectives are written to address observable changes in behavior, functioning or skills that foster the individual's ability to achieve their goals.

- 3 = All of the objectives are clearly stated and are NOT limited to participation in/receipt of a service
- 2 = Most of the objectives are clearly stated and are NOT limited to participation in/receipt of a service
- 1 = Some of the objectives are clearly stated and are NOT limited to participation in/receipt of a service
- 0 = None of the objectives are clearly stated and are NOT limited to participation in/receipt of a service

All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0

15. The objectives are measurable.

- 3 = All of the objectives are measurable
- 2 = Most of the objectives are measurable
- 1 =Some of the objectives are measurable
- 0 =None of the objectives measurable

All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0

16. The objectives are attainable and realistic and are based on the individual's current functioning and stage of change.

- 3 = All of the objectives are attainable and realistic and are based on the individual's current functioning and stage of change
- 2 = Most of the objectives are attainable and realistic and are based on the individual's current functioning and stage of change
- 1 = Some of the objectives are attainable and realistic and are based on the individual's current functioning and stage of change
- 0 = None of the objectives are attainable and realistic and are based on the individual's current functioning and stage of change

All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0

17. The interventions specify the frequency, number of units, duration, staff member responsible, and type of services to be provided.

- 3 = All of the interventions specify the frequency, number of units, duration, staff member responsible and type of services to be provided
- 2 = Most of the interventions specify the frequency, number of units, duration, staff member responsible and type of services to be provided
- 1 = Some of the interventions specify the frequency, number of units, duration, staff member responsible and type of services to be provided
- 0 = None of the interventions specify the frequency, number of units, duration, staff member responsible and type of services to be provided

All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0

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- 18. The interventions specify the purpose/intent as it relates to the Recovery Plan goals and objectives.
 - 3 = All of the intervention specify the purpose/intent of services to be provided
 - 2 = Most of the interventions specify the purpose/intent of services to be provided
 - 1 = Some of the interventions specify the purpose/intent of services to be provided
 - 0 = None of the interventions specify the purpose/intent of services to be provided
 - All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0
- 19. The Recovery Plan incorporates actions/contributions by natural supports (friends, family, peers, and community).

Yes No NA

20. Interventions include self-directed action steps based on the individuals strengths and identified interests.

Yes No

- 21. There is a description of the individual's participation in the recovery planning process and there is evidence that the Recovery Plan was completed in consultation with the individual. This may be evidenced by quotes, documentation of input, and/or signature(s) from the person receiving services and/or LAR.
 - 3 = All three elements are present
 - 2 =Two elements are present
 - 1= One element is present
 - 0 = No elements are present

Elements considered in this question are:

Quotes, Documentation of input, Signature(s)

Comments:

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Appendix C

Person Centered Care Questionnaire (PCCQ) — Provider (P) Version

Person Centered Care Planning Questionnaire — Provider (P) Version

Tondora, J., & Miller, R. (2009). Yale Program for Recovery and Community Health.

Please indicate the degree to which you agree or disagree with the following statements about your experiences of treatment planning.

The scale ranges from 1 for strongly disagree to 5 for strongly agree, with the following options in between. It also is possible to check DK if you feel you do not know how to rate a specific item.

1 2 3 4 5
Strongly Disagree Neither Agree Agree Strongly
Disagree nor Disagree Agree

		1	2	3	4	5
1.	I remind each person that she or he can bring family members or friends to treatment planning meetings.					
2.	I offer each person a copy of his or her plan to keep.					
3.	I write treatment goals in each person's own words.					
4.	Treatment plans are written so that each person and his or her family members can understand them. When professional language is necessary, I explain it.					
5.	I ask each person to include healing practices in his or her plan that are based on his or her cultural background.					
6.	I encourage each person to include other providers, like vocational or housing specialists, in their meetings.					
7.	I include each person's strengths, interests, and talents in his or her plan.					
8.	I link each person's strengths to objectives in his or her plan.					
9.	I make sure that plans include the next few concrete steps that each person has agreed to work on.					
10.	I include those areas of each person's life that he or she wants to work on (like health, social relationships, getting a job, housing, and spirituality) in his or her plan.					
11.	I try hard to understand how each person accounts for what has happened to them and how they see their experiences based on their cultural background.					
12.	I include in treatment plans the goals that each person tells me are important to them.					
13.	I develop care plans in a collaborative way with each person I serve.					
14.	I encourage each person to set the agenda for his or her treatment planning meetings.					
15.	I use "person-first" language when referring to people in the plan, i.e., "a person with schizophrenia" rather than a "schizophrenic."					
16.	I consider cultural factors (such as the person's spiritual beliefs and culturally-based health/illness beliefs) in all parts of the treatment planning process.					
17.	I let each person know ahead of time about their treatment planning meetings.					
18.	I include goals and objectives in treatment plans that address what each person want to get back in his or her life, not just what he or she is trying to avoid or get rid of.					

19.	I explain to each person how much time they have to work on each step in their plan.		
20.	As part of planning meetings, I educate each person about his or her rights and responsibilities in care.		
21.	I identify an explicit role and action step(s) for each person in the interventions section of his or her plan.		
22.	I also identify explicit roles/action steps for each person's supporters in the interventions section of the plan.		
23.	I offer education about personal wellness and self-determination tools such as WRAP and advance directives as part of the planning process.		
24.	The interventions and action steps identified in the plan encourage the person's connection to integrated/natural settings and supporters (rather than segregated settings designed only for people with mental illness).		
25.	I ask about cultural beliefs and areas of each person's cultural background that I do not understand to enhance the cultural relevance of the planning process.		
26.	I support people in pursuing goals such as housing or employment, even if they are still struggling actively with medication adherence, sobriety, or clinical symptoms.		
27.	I offer education about peer-based services and mutual support groups as part of the planning process.		
28.	If requested or needed, I utilize bilingual/bicultural translators throughout the care process.		
29.	I build attention to each person's cultural preferences and values into the process of writing a person-centered plan.		
30.	Each person is involved in the treatment planning process as much as he or she wants to be.		
31.	I identify the purpose of each intervention in the plan to link it to the person's identified goals and objectives.		
32.	I give each person the chance to review and make changes to his or her care plan.		

The most positive part of treatment planning has been				
One thing I would improve about doing treatment planning would be				

THANK YOU!