Person-Centered Recovery Planning Pilot Project: Final Evaluation Report

August 2015

TIEMH

Texas Institute for Excellence in Mental Health

Amy Lodge, Ph.D.
Laura Kaufman, M.A.
Stacey Stevens Manser, Ph.D.

Texas Institute for Excellence in Mental Health
School of Social Work
University of Texas at Austin
1717 West 6th Street, Suite 335
Austin, Texas 78703
Phone: (512) 232-0616
Fax: (512) 232-0617
E-mail: Txinstitute4mh@austin.utexas.edu
http://sites.utexas.edu/mental-health-institute/

Suggested citation: Lodge, A., Kaufman, L., and Stevens Manser, S. 2015. Person-Centered Recovery Planning Pilot Program: Final Evaluation Report. Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin.

Introduction

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" (p. 6). 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, 2002) and there is growing evidence that PCP is effective in the mental health field (Stanhope, Ingoglia, Schmelter, & Marcus, 2013). PCP provides a framework for individuals to partner with providers to select services that meet their needs in moving towards a life goal and meet the requirements of medical necessity. 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).

Via Hope, Texas Mental Health Resource, has facilitated the Person-Centered Recovery Planning (PCRP) Initiative in the state of Texas since federal fiscal year 2012. Researchers from the Texas Institute for Excellence in Mental Health (TIEMH) have been responsible for ongoing evaluation efforts since the program was initiated. PCRP aims to enhance recovery-oriented, person-centered care and services within mental health organizations across the state of Texas, with an emphasis on training and coaching of direct care practitioners and clinicians. Participating organizations include Austin State Hospital (ASH) and Bluebonnet Trails Community Services (BTCS) who began participating in FY2012 and Austin Travis County Integral Care (ATCIC) and Hill County Community MHDD Centers (HC) who joined the initiative in FY2013. Each site was provided various types of support throughout the pilot project including training, coaching, and technical assistance tailored to the needs of the organization.

Technical Assistance Provided by Via Hope

In FY2012, Via Hope brought in national subject matter experts to deliver training and coaching to ASH and BTCS and provided implementation support to these sites in collaboration with consultants. In FY2013, two additional sites joined the pilot project: ATCIC and HC. During this year, Via Hope provided organizations with more support compared to the previous fiscal year. However, this level of intensive technical assistance could not be managed for an extended period of time; staff at some organizations began experiencing implementation fatigue. Three of the four organizations requested a decrease in technical assistance. Thus, in FY2014, Via Home shifted the focus of technical assistance to developing organizations from within in order to increase leadership and ownership of PCRP implementation. Whereas in previous years training and coaching were provided to organizations by Via Hope, in FY2014 organizational staff began providing PCRP training and coaching to staff within their organization. Specific technical assistance activities provided over the 3 years of the pilot program are presented in Table 1.

Site Specific Information

Austin State Hospital

ASH covers a catchment area of 38 counties, admitting over 4,000 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. In FY2014, PCRP implementation efforts spread to Adult Psychiatric Services B (APS-B), which serves forensic populations, and Child and Adolescent Psychiatric Services (CAPS). While PCRP implementation was focused on these two units in FY2014, the PCRP template in the electronic health record was disseminated to all units within the organization and most of the units were receiving coaching and training from internal coaches and trainers.

Austin Travis County Integral Care

ATCIC serves individuals in Travis County. They operate 16 facilities, with a new integrated care clinic that opened 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. By FY2014, ATCIC spread PCRP practices across many clinics, service packages, and populations throughout the organization and developed a committee to oversee PCRP implementation.

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 Travis County. Participation in the PCRP Initiative began at the administrative offices 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. In FY2014, PCRP implementation efforts remained in Williamson, Caldwell, and Gonzales counties.

Hill Country Community MHDD Centers

HC first participated in the PCRP initiative in FY2013. This organization has an immense catchment area with 10 clinics 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. In FY2014, PCRP implementation efforts continued in Kerrville and San Marcos while internal coaches and trainers began providing PCRP implementation support to the remaining 8 clinics.

Table 1. Technical Assistance Provided by Via Hope from FY2012 to FY2014.

Technical Assistance Activity	FY2012	FY2013	FY2014
Introductory/Orientation Activities			
Orientation to PCRP	•	•	
PCRP Welcome Call		•	
PCRP Webinar			•
Training			
PCRP Skills Training	•	•	
PCRP Refresher Training	•		
Training for PCRP Trainers			•
Coaching and TA Calls			
Monthly Plan-Based TA Calls	•		
Bi-Monthly Plan-Based TA Calls		•	
Bi-Monthly Plan-Based TA Calls (Coach-the-Coach Model)			•
Training for Coaches			•
Coach Workshop or Consultation			•
Implementation Support			
PCRP Rollout Planning	•		
Monthly Leadership Calls	•	•	•
Statewide PCRP Workgroup Calls	•	•	
Site- or Discipline- Specific Technical Assistance			
Tailored TA Site Visits		•	
Peer Specialist Training/Technical Assistance	•	•	•
Supervisor's Training		•	
Psychiatrist Technical Assistance		•	•
Conferences and Events			
Recovery Launch Event	•		
Recovery Institute Conference			•

FY2015 Activities

In FY2015, Via Hope had limited contact with PCRP Pilot Program sites for a number of reasons. The sites began taking ownership of PCRP implementation efforts and requested fewer TA calls, leadership calls, and other time-intensive support. Internal staff at organizations became responsible for coaching and training staff on PCRP. While Via Hope-provided support gradually diminished, the program did not have a clear end. Further, the Via Hope PCRP Team has been tasked with developing online PCRP training modules to be utilized primarily by organizational staff across the state. The modules will provide an overview of recovery-oriented and person-centered care, strategies for partnering with people, and core components of person-centered care practices. In addition to develop online training modules, Via Hope staff has been planning for the next PCRP program to begin in FY2016.

The evaluation team wrapped up activities with sites by administering surveys to staff and consumers at participating organizations, reviewing a sample of person-centered recovery plans, and conducting focus groups with leadership teams, practitioners, and peer specialists. This report presents findings from these three data sources, synthesizes the main findings, and provides recommendations to Via Hope and DSHS in order to improve PCRP programming and implementation. These evaluation efforts were approved by the University of Texas Institutional Review Board and the Department of State Health Services Institutional Review Board #2.

METHODS

Survey Data

PCRP surveys were administered to staff and consumers at all four organizations that participated in the pilot program to assess implementation of person-centered care and practices at each of the organizations. Survey items for staff included a revised version of the Person-Centered Care Questionnaire (Tondora & Miller, 2009) to assess the implementation of person-centered practices at the organization; a question about implementation drivers; an open-ended question about the best parts of the recovery planning process; and an open-ended question about changes or improvements to the recovery planning process. Survey items for consumers included a revised version of the Person-Centered Care Questionnaire (Tondora & Miller, 2009); a question about whether or not the consumer works with a peer specialist; a question about implementation drivers; an open-ended question about the best parts of the recovery planning process; an open-ended question about changes or improvements to the recovery planning process; the Maryland Assessment of Recovery Scale to measure recovery at the individual consumer level; a question about quality of life; a question about stage of recovery; and an open-ended question about things consumers find important to living the life they want.

Staff surveys were administered online, with evaluators sending a link and draft email invitation to a contact person at the site who then sent the email to organization staff. One site also requested paper copies of the survey for staff who do not regularly access their email. For the consumer survey, paper copies were either mailed or hand delivered to the sites and included instruction sheets for survey administration. Researchers met with individuals from 3 of the 4 sites in-person to explain the purpose of the survey and survey administration procedures. Table 2 below presents the number of staff and consumer respondents at each organization.

Table 2: Survey Participants

Number of Participants	ASH	ATCIC	BTCS	HC	Total
Staff	194	51	14	46	305
Consumer	53	279	42	67	441
Total	247	330	56	113	746

Paper survey data was entered into Microsoft Excel using a combination of scanning software and manual data entry, Paper and online survey data was then was imported into IBM SPSS Statistics v.21, where the quantitative data was subsequently analyzed. Data from open-ended questions were analyzed using NVIVO qualitative data analysis software.

Plan Review

Researchers conducted a cross-sectional review of a sample of plans from ASH and HC (ATCIC and BTCS declined to participate despite being interested in this evaluation activity) using a modified version of the PCRP Quality Improvement Review Tool. In order to focus the review primarily on mental health and substance use issues, problems, goals, barriers, objectives, and interventions related to physical health and competency restoration/legal issues were not reviewed.

Researchers reviewed 397 ASH plans from FY 2011 (which serves as a baseline prior to project start) to FY 2014 (when Via Hope-provided training and coaching support ended) and 302 HC plans from FY 2012 (which serves as a baseline prior to project start) to FY 2014 (when Via Hope-provided training and coaching support ended). For each fiscal year of interest (FY 2011 (ASH only), 2012, 2013, 2014), researchers obtained a list of all plans either created or updated in the month of August, which is the last month of the fiscal year. For ASH, 470 plans were created or updated for 317 distinct individuals in August 2011, 438 plans were created or updated for 323 individuals in August 2012, 427 plans were created or updated for 299 individuals in August 2013, and 368 plans were created or updated for 260 individuals in August 2014.

For HC, 144 plans were created or updated in August 2012, 154 plans were created or updated in August 2013, and 109 plans were created or updated in August 2014. Due to time constraints, the sample was further narrowed down to 100 plans for each fiscal year for each organization. A stratified random sample was utilized to ensure each unit or clinic within the organization was represented in a proportion equal to the overall "population" of plans. This allowed researchers generalize findings the organization as a whole without reviewing the entire population of plans, which would be a time-intensive task. Researchers were also able to compare plans from units that had received training and coaching to those that had not.

Some of the selected plans were not coded by the research team, as they did not include major sections within the plan (e.g., the plan included a narrative summary, but did not include problem(s)/barrier(s), goal(s), objective(s) or intervention(s) sections). Therefore, the final sample included 397 plans from ASH with a roughly equal number from 2011 (n=101), 2012 (n=99), 2013 (n=99), and 2014 (n=98); while the final sample from HC included 302 plans with a roughly equal number from 2012 (n=101), 2013 (n=101), and 2014 (n=100). In total, the researchers reviewed 699 plans from two organizations. Table 3 below presents the number of plans reviewed by fiscal year and organization.

Table 3: Plans Reviewed

Fiscal Year	ASH	HC	Total
2011	101	--	101
2012	99	101	200
2013	99	101	200
2014	98	100	198
Total	397	302	699

Due to research staff availability, the plan review process differed slightly between ASH and HC, but inter-coder reliability was established for both site reviews. At ASH, four research staff reviewed the plans compared to two research staff reviewing the plans at HC. For both organizations, reliability in coding among research staff was assured by using a three-step process. First, one plan was randomly selected from each organization for research staff to independently code. The team then met to discuss coding agreements, disagreements, and steps for moving forward. Second, the team coded 10% of all plans for each organization, with each plan being independently coded by two members of the research team. In this second round, 70% inter-coder reliability was reached at ASH and 74% inter-coder reliability was reached at HC – that is for 70% and 74% of the PCRP Quality Improvement Review Tool items, coders agreed with one another. Then all coders discussed discrepancies in coding until consensus was reached on how to code each item of each plan. Third, this process was repeated by coding an additional 5% of all plans from each organization, which yielded 80% inter-coder reliability at ASH and 84% inter-coder reliability at HC – that is for 80% and 84% of the PCRP Quality Improvement Review tool items coders agreed with one another. Again, discrepancies in coding were

addressed until consensus was reached on each individual plan. Because 80% inter-coder reliability is generally considered an acceptable level of reliability, the remaining plans were randomly assigned to one of the coders. For ASH, two individuals on the research team each coded 149 plans while the other two team members each coded 20 plans. For HC, two individuals on the research team each coded approximately 128 plans.

PCRP Quality Improvement Review Tool

In FY 2013, consultant experts (Dr. Janis Tondora and Diane Grieder), Texas Department of State Health Services (DSHS) staff, Via Hope staff, a member of the TIEMH evaluation team, and practitioners in the field who were participating in the PCRP initiative developed the PCRP Quality Improvement Review Tool, which was used by DSHS to conduct an audit of a small number of plans at PCRP-participating Local Mental Health Authorities (LMHAs) and all other LMHAs in the state. For the current plan review, researchers selected this tool to review plans as it is anticipated that DSHS will utilize this tool on an ongoing basis. However, for this process several changes were made to the tool in order to effectively and efficiently code plans. Specifically, the tool was modified to address the following problems: 1) response choices did not match the item, 2) response choices were not discrete/mutually exclusive, 3) response choices were not exhaustive, 4) researchers did not have access to the comprehensive assessments, and/or 5) items were not meaningful for hospital plans as the tool had been developed to assess recovery plans at community centers. These modifications are detailed in Appendix A.

Focus Groups

In October and November 2014, evaluators conducted a total of nine focus groups with 71 staff members at ASH, ATCIC, and HC. BTCS declined to participate due lack of direction regarding future PCRP implementation efforts. Three focus groups were conducted at each participating organization: one with leadership (i.e., individuals who had been particularly instrumental in implementing PCRP); one with practitioners (primarily case managers at the community centers and treatment team members at the state hospital); and one with peer specialists. Prior to the focus groups, evaluators sent each organization a list of suggested attendees based on who had been involved in PCRP implementation, although the extent to which this list was reflective of focus group participants was variable across groups. Organizations were also informed that focus groups should ideally have between 6 and 12 participants, although again this was variable across groups and focus group size ranged from 3 to 13. Table 4 presents the number of individuals who participated in each focus group.

Table 4: Focus Group Participants

Number of Participants	ASH	ATCIC	HC	Total
Leadership	10	11	8	29
Peer Specialist	12	4	3	19
Practitioner	13	4	6	23
Total	35	19	17	71

Focus group participants were asked to reflect on accomplishments related to PCRP implementation; factors contributing to those accomplishments; resources they found helpful in implementing PCRP; barriers to implementing PCRP; factors contributing to those barriers; and future needs related to PCRP implementation. Focus groups lasted between one and one and half hours and, with participants' permission, were recorded with a digital recorder. Focus group data were transcribed and then analyzed using NVIVO qualitative data analysis software.

FINDINGS

Survey Data

Person-Centered Care Questionnaire (PCCQ)

The Person-Centered Care Questionnaire (PCCQ; Tondora & Miller, 2009) was administered to both staff and consumers to assess implementation of person-centered practices at the organization. The staff version of the questionnaire was modified from the original version by research staff, who discussed the changes with the

instrument developer prior to administration. The final modified version contained 31 items with a 5-point frequency scale ranging from 1=Never to 5=Always. The consumer version of the questionnaire contained 10 items with response choices of "Yes," "No," and "I don't know."

Findings from both the staff and consumer versions of the PCCQ indicate that person-centered practices related to the plan document were being implemented more frequently compared to practices related to the planning process. For example, consumers reported the following person-centered practices being carried out most frequently: the inclusion of meaningful life goals in the recovery plans; the inclusion of self-directed action steps in the plans; and understanding his or her recovery plan upon reading it. Table 5 presents the percentage of consumer respondents selecting "Yes" on each of the 10 items of the PCCQ. Similarly, staff reported the following person-centered practices being carried out most frequently: using bilingual/bicultural translators; including an individual's strengths, interests, and talents in his or her recovery plan; and including meaningful life goals in the recovery plan. Table 6 presents the mean response on each item of the PCCQ staff version of the survey. Practices less frequently reported include staff reminding consumers to bring natural supports to the planning meetings (consumer and staff); having a recovery plan that gets the person involved in the community (consumer only); encouraging individuals to include other individuals in the planning meetings (staff only); explaining how much time an individual has to complete each step (staff only); and having the opportunity to work with a peer specialist (consumer only). While approximately 66% of consumers reported being providing the opportunity to work with a peer specialist, only 36% of respondents reported working with a peer specialist.

Overall, these findings are not particularly surprising considering that the primary focus of training, coaching, and technical assistance provided to organizations had been the development of person-centered *plans* that include all of the elements critical to person-centered, recovery-oriented care. Less attention was placed on the planning *process* itself, including how to develop rapport and a partnership with the person receiving services as well as how to facilitate a planning meeting.

Table 5: Percentage of Respondents Selecting "Yes" on Consumer Version of PCCQ

PCCQ Item	All Sites (% Yes)
When I read my recovery plan, I understand it. If there is something I don't understand, staff explain and answer my questions.	84%
When my recovery team and I work on my recovery plan, we work together as partners.	79%
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.	69%
My strengths and talents are talked about in my recovery plan.	78%
I am offered a copy of my recovery plan to review and keep.	75%
I have the opportunity to work with a Peer Specialist or Coach if I want help getting ready for my recovery planning meeting.	66%
As part of my plan, I have things that I'm supposed to do to work on my goals.	86%
My recovery plan has goals (hopes and dreams) that are important to me and are about more than just symptom management.	90%
Staff support me in making my own decisions to try new things now, instead of waiting until my symptoms are better.	82%
Staff here remind me that I can bring my family, friends, or other supportive people to my recovery planning meetings.	65%

Table 6: Mean Scores on Staff Version of the PCCQ

PCCQ Item	Mean*
If requested or needed, bilingual/bicultural translators are utilized throughout the care process.	4.45
Each person's strengths, interests, and talents are included in his or her plan.	4.42
The goals that each person tells me are important to them are included in their recovery plan.	4.41
Each person is involved in the recovery planning process as much as he or she wants to be.	4.32
Recovery plans are developed in a collaborative way with each person served.	4.31
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) are included in his or her plan.	4.30
Each person is offered a copy of his or her recovery plan to keep.	4.29
Recovery plans are written so that each person can understand them. If professional language is necessary, it is explained to the person.	4.22
Staff at my organization use person first language when referring to people in the plan, i.e., a person with schizophrenia rather than a schizophrenic.	4.22
The purpose of each intervention is identified in the plan to link it to the person's identified goals and objectives.	4.19
Education about peer-based services and mutual support groups are offered as part of the planning process.	4.17
Each person is informed ahead of time about their recovery planning meetings.	4.15
Goals and objectives included in recovery plans address what each person wants to get back in his or her life, not just what he or she is trying to avoid or get rid of.	4.15
Cultural factors (such as the person's spiritual beliefs and culturally based health/illness beliefs) are considered in all parts of the recovery planning process.	4.14
Each person is given the chance to review and make changes to his or her recovery plan.	4.14
People are supported in pursuing goals such as housing or employment, even if they are still struggling actively with medication adherence, sobriety, or clinical symptoms.	4.11
Recovery goals are written in each person's own words.	4.10
Each person's strengths are linked to objectives in his or her plan.	4.10
Recovery plans include the next few concrete steps that each person has agreed to work on.	4.07
Explicit roles and action step(s) are identified for each person in the interventions section of his or her plan.	4.07
As part of planning meetings, each person is educated about his or her rights and responsibilities in care.	4.04
Staff at my organization build each person's cultural preferences and values into the process of writing a person-centered plan.	4.01
Explicit roles/action steps are identified for each person's supporters in the interventions section of the plan.	3.90
The recovery plan helps each person get involved in the community and not just in places that provide services for people with mental illness.	3.84
Cultural beliefs and areas of each person's cultural background that are not understood are asked about to enhance the cultural relevance of the planning process.	3.80
Each person is encouraged to set the agenda for his or her recovery planning meetings.	3.79
Each person is asked to include healing practices in his or her plan that are based on his or her cultural background.	3.75
Education about personal wellness and self-determination tools such as WRAP and advance directives are offered as part of the planning process.	3.65
Each person is reminded that she or he can bring family members or friends to recovery planning meetings.	3.62
Staff at my organization explain to each person how much time they have to work on each step in their plan.	3.62
Each person is encouraged to include other providers, like vocational or housing specialists, in their meetings.	3.60

**Answer choices are as follows: 1=Never, 2=Rarely, 3=Sometimes, 4=Often, 5=Always; higher scores indicate a higher frequency of the practice being implemented at the organization*

Implementation Drivers

The evaluation team used implementation science to frame many of the evaluation and quality improvement findings throughout the course of the pilot project. As such, staff were asked to report organizational ability to implement PCRP related to eight implementation drivers: selection, training, coaching, systems interventions, facilitative administration, data systems, adaptive leadership, and technical leadership. Overall, staff reported that their organizations excelled at selecting appropriate staff to carry out PCRP implementation (m=7.1 out of 10); coaching capabilities (m=6.9); training (m=6.9); and adaptive leadership (m=6.9). They rated their organizations the lowest on facilitative administration (m=6.5), systems interventions (m=6.7), and data systems (m=6.7), all of which fall under the broader category or organizational drivers. Amongst the broad driver categories, sites received the highest scores on competency drivers (selection, training, and coaching' m=7.0) and the lowest scores on organizational drivers (systems interventions, facilitative administration, and data systems; m=6.7) and performance assessment (m=6.6). Mean ratings on each of the implementation drivers as well as the broader categories of drivers are presented in Table 7. Again, much of the support provided by Via Hope focused on providing training and coaching and developing training and coaching capacities within the organization by offering two trainings for PCRP trainers, several coach workshops, and using a Coach-the-Coach model on technical assistance calls. Less emphasis was placed on other implementation areas, although consultants did share tools and strategies with teams and leadership that supported practice implementation. For a practice to be implemented successfully, organizations much approach implementation holistically rather than focusing on a few targeted areas.

Table 7: Mean Ratings on Implementation Drivers

Implementation Driver	All Sites
Competency Drivers	7.0
Selection	7.1
Training	6.9
Coaching	6.9
Organizational Drivers	6.6
Systems Interventions	6.7
Facilitative Administration	6.5
Data Systems	6.7
Leadership Drivers	6.9
Adaptive Leadership	6.9
Technical Leadership	6.8
Performance Assessment	6.6

Best Part of the Recovery Planning Process

Staff and consumers were asked to indicate the best part of the recovery planning process. Responses from consumers included support from staff (23%), talking to staff (13%), better relationships between consumers and staff (13%), and life goals being on track (10%). Staff responses included consumer involvement in planning (39%), focus on consumer's goal(s) (19%), consumer in the driver's seat (15%), and individualized recovery plans (8%). Both staff and consumers indicated that one of the best part of recovery planning is that it has resulted in better consumer-level outcomes (23% of consumer respondents, 19% of staff respondents). Further examination or identification of relevant PCRP consumer-level outcomes may warranted in order to tie PCRP to positive improvements in the lives of individuals receiving services.

Changes or Improvements to the Planning Process

Staff and consumers were also asked to indicate ways to improve the planning process. The most common consumer responses included: more services (10%), change in medicine (6%), support from caseworker (4%), and more peer specialist services (4%). The most common staff responses included: more staff training (18%), implementation across units (13%), simplification of the planning document (7%), more staff involvement (5%) and improvements to software (5%). Both consumers and staff indicated that more time (3% of consumer respondents, 10% of staff respondents) and more consumer involvement (3% of consumer respondents, 4% of staff respondents) would improve the planning process.

Maryland Assessment of Recovery Scale (MARS)

The Maryland Assessment of Recovery Scale (MARS) is a 25-item instrument that measures recovery at the individual consumer level. Items reflect the recovery domains outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA). Respondents were asked to indicate their agreement with each item on a 5-point scale ranging from "not at all" to "very much." Across organizations, consumers agreed the most with statements related to personal responsibility for physical health (m=4.23) and making changes in one's life (m=4.09) and goal setting (m=4.04). On the other hand, they indicated lower levels of agreement on items related to feeling loved (m=3.48), acceptance (m=3.48), ability to make good choices (m=3.44), and feeling good about oneself (m=3.20). Table 8 below presents he mean scores on the MARS for all consumer respondents. When examining differences between sites on the MARS, consumers from the two organizations that had been participating in the project for a longer period of time reported higher average scores compared to consumers from the other two organizations. This may be due to the fact that there is a lag between implementation and positive outcomes at the consumer level (Fixsen, Naoom, Blasé, Friedman & Wallace, 2005).

Table 8: Mean Scores on MARS

Item	Mean*
I am responsible for taking care of my physical health.	4.23
I am responsible for making changes in my life.	4.09
It is up to me to set my own goals.	4.04
Overcoming challenges helps me to learn and grow.	4.00
I want to make choices for myself, even if I sometimes make mistakes.	4.00
I believe that getting better is possible.	3.97
I work hard to find ways to cope with problems in my life.	3.84
I know that I can make changes in my life even though I have a mental illness.	3.82
I am able to set my own goals in life.	3.79
I am confident that I can make positive changes in my life.	3.75
I believe that I am a strong person.	3.75
I have skills that help me to be successful.	3.74
My strengths are more important than my weaknesses.	3.74
When I have a relapse, I am sure that I can get back on track.	3.73
I am hopeful about the future.	3.73
I have abilities that can help me reach my goals.	3.71
I can bounce back from my problems.	3.61
I can have a fulfilling and satisfying life.	3.60
I am optimistic that I can solve problems that I will face in the future.	3.55
I can influence important issues in my life.	3.54
I usually know what is best for me.	3.51
I feel loved.	3.48
I feel accepted as who I am.	3.48
I believe I make good choices in my life.	3.44
I feel good about myself even when others look down on my illness.	3.20

**Answer choices are as follows: 1=Not at all, 2=A little bit, 3=Somewhat, 4=Quite a bit, 5=Very much; higher scores indicate a greater level of agreement with the item.*

Quality of Life

Consumer quality of life was assessed using a single item from SAMHSA's National Outcomes Measures. Consumers were asked to respond to the item, "How would you rate your overall health right now?" on a 5-point scale, where 1=poor, 2=Fair, 3=Good, 4=Very Good and 5=Excellent. The majority of respondents indicated their overall quality of life as being fair (32%) or good (31%) across the organizations. Average quality of life scores were calculated for each organization and across all respondents. Overall, consumer quality of life was 2.80, which is a value that falls in between fair and good. Similar to the MARS, consumers from the two organizations that had been participating in the project for a longer period of time reported higher average quality of life scores compared to consumers from the other two organizations.

Stage of Recovery

Consumers reported their involvement in the recovery process using a modified version of the "Recovery Involvement" item from the Recovery Marker's Questionnaire (Ridgway, 2005). The response choices correspond to the well-known stages of recovery. Half (50%) of the respondents indicated being actively involved in the recovery process (action stage of change) while an additional 23% of respondents indicated that they are committed to their recovery and are taking action very soon (preparation stage of change). Practitioners were encouraged to both specify the individual's stage of change in the narrative summary and develop a plan based on the person's readiness or stage of change.

Things Important to Living the Life You Want

Consumers were asked to indicate the things that they find important to living the kind of life they would like to live. The most frequently reported categories were: financial security (20%), home (18%), family (16%), better mental health (14%), job (13%), friends (11%), religion (9%), and independence (9%). Not surprisingly, these categories are similar to what most people want in their lives. Practitioners should ensure that a person's individualized recovery life goal is captured in the person's plan so the person can clearly see that the services they receive are in pursuit of their chosen life goal.

Plan Review

Table 9 summarizes the findings of our review of ASH (FY 11-14) and HC (FY 12-14) plans using the PCRP Quality Improvement Review Tool. ***Important note:*** In order to accurately assess the effectiveness of Via Hope training and coaching and account for the fact that training and coaching started in 2012 at ASH and 2013 at HC, we compared Time 1 plans (which include ASH 2011 and HC 2012 plans and serve as baseline prior to project start), Time 2 plans (which include ASH 2012 and HC 2013 plans), Time 3 plans (which include ASH 2013 and HC 2014 plans), and Time 4 plans (which only include ASH 2014 plans). In this section we describe each item on the tool as well as note any trends from Time 1 to Time 4 and if differences emerged between units/clinics that did and did not receive Via Hope training and coaching.

Table 9: Plan Review Findings

Item	Time 1	Time 2	Time 3	Time 4
The recovery goals and objectives are linked to the narrative summary/formulation.				
Yes	52%	57%	74%	74%
No	3%	5%	15%	26%
Not applicable	45%	39%	12%	0%
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	31%	32%	50%	77%
No	69%	69%	50%	23%
The Recovery Plan goals are written in the individuals own words				
Yes	48%	58%	62%	86%
No	52%	42%	38%	14%
The Recovery Plan includes a description of the presenting problem/barriers to goal attainment as a result of the mental health or substance use issues.				
Problem/barrier IS NOT linked to goal AND DOES NOT address MH/SU	11%	9%	5%	14%
Problem/barrier is linked to goal OR addresses MH/SU, but not both.	22%	22%	26%	30%
Problem/barrier is linked to goal AND addresses MH/SU	66%	70%	69%	56%
The Recovery Plan includes the expected date by which the objectives will be achieved.				
None of the objectives specify the target date	25%	16%	20%	10%
Some of the objectives specify the target date	1%	3%	--	--
Most of the objectives specify the target date	3%	1%	5%	1%
All of the objectives specify the target date	71%	81%	76%	89%
The target dates for the objectives in the Recovery Plan vary (if relevant).				
None of the objectives in the Recovery Plan vary	50%	59%	36%	28%
Some of the objectives in the Recovery Plan vary	7%	3%	2%	--
Most of the objectives in the Recovery Plan vary	4%	3%	1%	3%
All of the objectives in the Recovery Plan vary	2%	2%	2%	5%
Not applicable	37%	34%	60%	63%
The Recovery Plan includes a description of the individual's strengths.				
Yes	97%	97%	97%	98%
No	3%	4%	3%	2%

Item	Time 1	Time 2	Time 3	Time 4
The individual's strengths are actively used in the Recovery Plan rather than just identified in the strengths field.				
Yes	6%	10%	26%	19%
No	94%	91%	74%	81%
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	3%	7%	3%	7%
No	36%	35%	33%	32%
Not applicable	61%	58%	64%	61%
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	44%	39%	26%	35%
No	35%	35%	30%	11%
Not applicable	21%	27%	44%	54%
If co-occurring substance use 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	34%	36%	32%	55%
No	8%	9%	12%	5%
Not applicable	58%	56%	57%	40%
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	2%	4%	5%	3%
No	25%	25%	27%	24%
Not applicable	73%	72%	68%	72%
If cognitive, intellectual, or developmental disabilities 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	4%	6%	5%	10%
No	8%	6%	9%	13%
Not applicable	88%	89%	86%	77%
The objective(s) can be linked back to barriers and issues identified in the narrative summary/formulation, weaknesses, and/or problem/barriers section.				
None of the objectives can be linked to barriers/issues	6%	7%	5%	9%
Some of the objectives can be linked to barriers/issues	4%	7%	2%	--
Most of the objectives can be linked to barriers/issues	24%	21%	6%	6%
All of the objectives can be linked to barriers/issues	65%	66%	87%	85%
The objectives describe behavioral changes.				
None of the objectives describe behavioral changes	13%	14%	14%	19%
Some of the objectives describe behavioral changes	9%	18%	13%	1%
Most of the objectives describe behavioral changes	57%	44%	24%	22%
All of the objectives describe behavioral changes	21%	25%	50%	57%
The objectives are measurable.				
None of the objectives are measurable	10%	8%	12%	12%
Some of the objectives are measurable	9%	7%	3%	--
Most of the objectives are measurable	30%	24%	10%	5%
All of the objectives are measurable	50%	62%	75%	83%
The objectives are attainable and realistic and are based on the individuals current functioning and stage of change.				
None of the objectives are attainable and realistic	2%	3%	5%	9%
Some of the objectives are attainable and realistic	3%	2%	1%	--
Most of the objectives are attainable and realistic	30%	37%	20%	13%
All of the objectives are attainable and realistic	64%	59%	74%	79%
The interventions specify the frequency.				
None of the interventions specify the frequency	--	1%	--	--
Some of the interventions specify the frequency	--	--	--	--
Most of the interventions specify the frequency	48%	39%	39%	61%
All of the interventions specify the frequency	52%	61%	61%	39%
The interventions specify the number of units.				
None of the interventions specify the number of units	14%	10%	22%	57%
Some of the interventions specify the number of units	50%	45%	32%	43%
Most of the interventions specify the number of units	7%	10%	10%	--
All of the interventions specify the number of units	29%	36%	36%	--

Item	Time 1	Time 2	Time 3	Time 4
The interventions specify the duration.				
None of the interventions specify the duration	49%	46%	46%	93%
Some of the interventions specify the duration	4%	5%	4%	7%
Most of the interventions specify the duration	4%	2%	4%	--
All of the interventions specify the duration	43%	49%	46%	--
The interventions specify the staff member responsible.				
None of the interventions specify the staff member responsible	15%	17%	10%	--
Some of the interventions specify the staff member responsible	3%	3%	5%	--
Most of the interventions specify the staff member responsible	9%	13%	7%	--
All of the interventions specify the staff member responsible	73%	68%	79%	100%
The interventions specify the type of services to be provided.				
None of the interventions specify the type of services to be provided	--	1%	--	1%
Some of the interventions specify the type of services to be provided	--	1%	8%	18%
Most of the interventions specify the type of services to be provided	12%	5%	14%	63%
All of the interventions specify the type of services to be provided	88%	94%	78%	19%
The interventions specify the purpose/intent as it relates to the objectives				
None of the interventions specify the purpose/intent	41%	24%	5%	1%
Some of the interventions specify the purpose/intent	3%	7%	5%	9%
Most of the interventions specify the purpose/intent	42%	39%	45%	54%
All of the interventions specify the purpose/intent	13%	31%	45%	36%
The Recovery Plan incorporates actions/contributions by natural supports (friends, family, peers, and community).				
Yes	38%	34%	36%	46%
No	62%	67%	64%	54%
Interventions include self-directed action steps based on the individuals strengths and identified interests.				
Yes	3%	15%	22%	3%
No	97%	86%	78%	97%
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.				
No elements are present	12%	2%	9%	1%
One element is present	68%	67%	55%	18%
Two elements are present	20%	31%	36%	81%
Three elements are present	--	--	--	--

The recovery goals and objectives are linked to the narrative summary/formulation.

This item measures whether or not the narrative/integrated summary/formulation is linked to the plan goals and objectives. Plans that did not include a narrative/integrated summary/formulation were scored as "not applicable." The percentage of plans meeting this criterion was higher at Time 3 and Time 4 (74% for both time points) than at Time 1 (52%) and Time 2 (57%).

Units and clinics that received Via Hope training and coaching were more likely to score a "yes" on this item, particularly at Time 4 (85% of plans from these units/clinics) compared to units and clinics that did not receive Via Hope training and coaching (68% of plans from these units/clinics), indicating that training and coaching may have been effective in this regard. The increase over time for all units, regardless of training/coaching received, might reflect a cultural shift or diffusion of the PCRP template within the electronic health record across the organization.

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.

This item measures whether or not at least one PCRP goal statement reflects a meaningful life goal outside of the mental health system. An example of a meaningful life goal outside of the mental health system from a Time 4 plan is: "Wants to be a cartoonist and get to create action figures." In contrast, an example of a goal that does not reflect a meaningful life goal outside of the mental health system comes from a Time 1 plan: "Will describe improved mood and state positive expectations for the future. Will not endorse any suicidal ideations or engage in any self-injurious gestures or threats, will not have any anger outbursts or endorse any hallucinations for a period of 1 week."

The percentage of plans that included at least one meaningful life goal increased dramatically from Time 1 when only 31% of plans met this criterion to Time 4 when 77% of plans did so. Units and clinics that received Via Hope training and coaching were also more likely to receive a "yes" on this item: overall, 52% of plans from units and clinics that received training/coaching included a meaningful life goal compared to only 36% of plans from units/clinics that did not receive training/coaching. This suggests that training and coaching were effective in this regard.

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

This item measures whether or not at least one goal is written in the person's own words. This was indicated either by the presence of quotes or by a first-person point of view. The percentage of plans that met this criterion increased dramatically from Time 1 to Time 4. At Time 1, 48% plans included a goal written in the person's own words, compared to 58% at Time 2, 62% at Time 3, and 86% at Time 4. Overall, there were not large differences on this item between units/clinics that did and did not receive training/coaching: 62% of plans from units/clinics that received training/coaching met this criterion compared to 59% of plans from units/clinics that did not.

The Recovery Plan includes a description of the presenting problem/barriers to goal attainment as a result of the mental health or substance use issues.

This item measures 1) whether plan problems/barriers are linked to plan goals and 2) whether problems/barriers address mental health and/or substance use issues. For example, the following problem from a Time 1 plan addresses mental health issues: "Patient exhibits symptoms of depression as evidenced by periods of increased depression and irritability, history of hallucinations, self-injurious behaviors and anger outbursts" and this problem is linked to the following goal: "Will describe improved mood and state positive expectations for the future. Will not endorse any suicidal ideations or engage in any self-injurious gestures or threats, will not have any anger outbursts or endorse any hallucinations for a period of 1 week." In contrast, an example of problem/barrier that is not linked to a goal and does not address mental health/substance use issues comes from a Time 4 plan: "Barrier: legal issues"; Goal: "[person] did not identify however the treatment team would like to see him exhibit a more organized thought process." The percentage of plans that met these criteria remained fairly stable from Time 1 to Time 4. There were also no differences between units/clinics that did and did not receive training and coaching on this item.

The Recovery Plan includes the expected date by which the objectives will be achieved.

This item measures the percentage of plan objectives that specify a target or due date. "None of the objectives specify the target date" indicates that 0% of the objectives have a due date. "Some of the objectives specify the target date" indicates that between 1-49% of objectives have a due date. "Most of the objectives specify the target date" indicates that between 50-99% of the objectives have a due date. "All of the objectives specify the target date" indicates that 100% of objectives have a due date.

From Time 1-4, plans were increasingly likely to specify a target date for all of the objectives, while it was decreasingly the case that none of the plan objectives specified a target date. For example, at Time 1, 71% of plans specified the due date of all plan objectives, compared to 81% of plans at Time 2, 76% at Time 3, and 89% at Time 4. Congruent with this trend, at Time 1, 25% of plans specified none of the objective due dates, compared to 16% of plans at Time 2, 20% at Time 3, and 10% at Time 4. Units/clinics that did not receive training/coaching were somewhat more likely to specify the due date of all of the plan objectives compared to units/clinics that did receive training/coaching: 83% of plans from units/clinics that did not receive training/coaching specified the due date of all of the plan objectives compared to 70% of plans from units/clinics that received training/coaching.

The target dates for the objectives in the Recovery Plan vary (if relevant).

This item measures the percentage of objective target dates that vary. "None of the objectives vary" indicates that 0% of objective target dates vary. "Some of the objectives vary" indicates that 1-49% of objective target dates vary. "Most of the objectives vary" indicates that 49-99% of objective target dates vary. "All of the objectives vary" indicates that 100% of the objectives vary. "N/A" indicates that either 1) a plan has only one objective or 2) one or none of the objectives have a target date (and therefore a comparison cannot be made).

The percentage of plans with no varying objective due dates declined from 50% at Time 1 to 28% at Time 4. Further, the percentage of plans receiving a "not applicable" on this item increased from 37% at Time 1 to 63% at Time 4. Units/clinics that received training/coaching were less likely to have no varying objective due dates (35% of plans from these units/clinics) compared to units/clinics that did not receive training/coaching (54% of plans from these units/clinics). Units/clinics that received training/coaching were also more likely to receive a "not applicable" on this item (57% of plans from these units/clinics) compared to units/clinics that did not receive training/coaching (38% of plans from these units/clinics. This difference likely does not reflect the fact that objective target dates were less likely to vary in units/clinics that received training/coaching, but rather that plans from these units/clinics were simpler and had fewer objectives.

The Recovery Plan includes a description of the individual's strengths.

This item measures whether plans included a description of the individual's strengths or not. The percentage of plans that included an individual's strengths was high for all four years (97% overall) and the percentage of plans meeting this criterion was also slightly higher for units/clinics that received training/coaching (98%) compared to plans from units/clinics that did not receive training/coaching (96%).

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

This item measures whether or not an individual's strengths were actively used in the plan rather than simply identified in the strengths field. For example, if a plan identified an individual's strength as leisure interests and an objective specified participating in group activities to develop and encourage this person's recreation and leisure interests, this was coded as a "yes" on this item. The percentage of plans meeting this criterion increased from 6% at Time 1 to 28% at Time 3 and 19% at Time 4. Further, 20% of plans from units/clinics that received training/coaching met this criterion compared to only 11% of plans from units/clinics that did not receive training/coaching, suggesting training/coaching was somewhat effective in this regard.

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.

This item measures 1) whether cultural issues are identified in a plan and 2) if identified, if cultural issues are addressed. Examples of cultural issues include a long history of hospitalization/institutionalization, religion or spirituality, homelessness, racial/ethnic identity, veteran status, or any other individual characteristic that might affect how services should be provided. If a cultural issue was identified but not addressed in the plan, this item was coded "No." In contrast, for example, if religion was identified as a significant factor in a person's life and the plan included an intervention that specified the person would attend church more often (or visit with the chaplain in an inpatient setting), this was coded as "Yes." If cultural issues were neither identified nor addressed, this item was coded as "N/A."

Overall, plans rarely addressed cultural issues and this was fairly stable from Time 1-4 (3% at Time 1 and Time 3 and 7% at Time 2 and 4). However, units/clinics that received Via Hope training were slightly more likely to identify and address cultural issues. Overall, 45% of plans from units/clinics that received training/coaching identified cultural issues compared to 35% of plans from units/clinics that did not receive training/coaching. Further, 8% of plans from units/clinics that received training/coaching both identified and addressed cultural issues compared to 3% of plans from units/clinics that did not receive training/coaching, suggesting that training/coaching was somewhat effective in this regard.

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.

This item measures 1) whether physical health issues are identified in a plan and 2) if identified, if physical health issues are addressed. From Time 1-4 two trends emerged: 1) plans were increasingly less likely to identify physical health issues (from 79% at Time 1 to 46% at Time 4) and 2) plans were increasingly less likely to address physical health issues that were identified (from 44% at Time 1 to 26% at Time 3 [this percentage dipped back up to 35% at Time 4 which only included ASH plans]). These trends likely reflect the fact that over time plans became shorter and were less likely to include every health issue.

There were not, however, large differences on this item between units/clinics that did and did not receive training/coaching. Overall, 38% of plans from units/clinics that did not receive training/coaching identified and addressed physical health issues compared to 34% of plans from units/clinics that received training/coaching.

If co-occurring substance 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.

This item measures 1) whether co-occurring substance use issues are identified in a plan and 2) if identified, if co-occurring substance use issues are addressed. The percentage of plans that addressed substance use issues was stable from Time 1 (34%) to Time 3 (32%). The percentage was higher at Time 4 (55%), which likely reflects the fact that Time 4 only includes ASH plans. Units/clinics that received training/coaching were less likely to address substance use issues (31% of plans from these units/clinics did so) compared to units/clinics that did not receive training/coaching (41% of plans from these units/clinics). One possible explanation for this trend is that substance use objectives and interventions were typically standardized and did not vary from plan to plan and units/clinics that received coaching/training may have been more likely to rely less on standardized plan objectives/interventions, instead writing more innovative and individualized objectives/interventions.

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.

This item measures 1) whether trauma issues are identified in a plan and 2) if identified, if trauma issues are addressed. The percentage of plans that identified and addressed trauma was fairly stable from Time 1 to Time 4. For example, 2% of plans addressed trauma at Time 1, compared to 4% at Time 2, 5% at Time 3, and 3% at Time 4. Units/clinics that received training/coaching were somewhat more likely to identify and address trauma, however, compared to units/clinics that did not receive training/coaching. For example, 36% of plans from units/clinics that received training/coaching identified trauma, compared to only 24% of plans from units/clinics that did not.

If cognitive, intellectual, or developmental disabilities 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.

This item measures 1) whether cognitive, intellectual, or developmental disabilities are identified in a plan and 2) if identified, if cognitive, intellectual, or developmental disabilities are addressed. At Time 4, cognitive, intellectual, or developmental disabilities were somewhat more likely to be identified and addressed, compared to Time 1-3. For example, at Time 4, 10% of plans addressed these disabilities compared to 4% of plans at Time 1. Again, this difference may be due to the fact that Time 4 only includes ASH plans and these types of disabilities may be more common in hospitals compared to community centers. Units/clinics that received training/coaching were more likely to both identify and address cognitive, intellectual, or developmental disabilities than were units/clinics that did not receive training/coaching. Overall, 19% of plans from units/clinics that received training/coaching identified these types of disabilities compared to 10% of plans from units/clinics that did not receive training/coaching.

The objectives can be linked back to barriers and issues in the narrative/integrated summary, weaknesses/issues/needs, and/or problem/barriers section.

This item measures the percentage of objectives that can be linked back to barriers/issues identified in the narrative/integrated summary, weaknesses/issues/needs section, and/or problems/barriers section. If 0% of the objectives could be linked back to barriers listed in one of these sections, this was coded as “None of the objectives can be linked to barriers.” If 1-49% of the objectives could be linked back to barriers/issues listed in one of these sections, this was coded as “Some of the objectives can be linked to barriers.” If 50-99% of objectives could be linked back to barriers listed in one of these sections, this was coded as “Most of the objectives can be linked back to barriers” and if 100% could be, this was coded as “All of the objectives are linked to barriers.” From Time 1 to Time 4, the percentage of plans with all of the objectives linking back to identified barriers/issues increased from 65% to 85%. There were not large differences between units/clinics that did and did not receive training/coaching on this item.

The objectives describe behavioral changes.

This item measures the percentage of plan objectives that specify behavioral changes – that is observable actions on the part of the person receiving services. The following is an example of an objective that describes a behavioral change: "Within 14 days [person] will be able to identify and utilize at least two healthy coping skills he can use to manage his anger." In contrast, several objectives required that consumers identify or describe something (for example: "Medical - When prompted will be able to describe at least one way in which medication helps control psychotic symptoms and mood disturbance") and these types of objectives were not coded as behavioral changes. If 0% of the objectives in a plan were behavioral, this was coded as "None of the objectives are behavioral." If 1-49% of the objectives in a plan were behavioral, this was coded as "Some of the objectives are behavioral." If 50-99% of the objectives were behavioral this was coded as "Most of the objectives are behavioral" and if 100% were, this was coded as "All of the objectives are behavioral." From Time 1 to Time 4, plans were increasingly likely to have all behavioral objectives. For example, at Time 1 only 21% of plans had all behavioral objectives compared to 57% of plans at Time 4. Units/clinics that received training/coaching tended to do better on this item compared to units/clinics that did not receive training. For example, at Time 3, 70% of plans from units/clinics that received training/coaching had all behavioral objectives compared to only 36% of plans from units/clinics that did not receive training/coaching.

The objectives are measurable.

This item measures the percentage of plan objectives that are measurable – that is, there is some way to assess whether the objective could be achieved or not. If 0% of the objectives in a plan were measurable, this was coded as "None of the objectives are measurable." If 1-49% of the objectives in a plan were measurable, this was coded as "Some of the objectives are measurable." If 50-99% of the objectives were measurable this was coded as "Most of the objectives are measurable" and if 100% were, this was coded as "All of the objectives are measurable." From Time 1 to Time 4, the percentage of plans with all measurable objectives increased from 50% of plans at Time 1 to 83% of plans at Time 4. There were not large differences between units/clinics that did and did not receive training/coaching on this item.

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

This item measures the percentage of plan objectives that are attainable and realistic – that is within the reach of the person receiving services within the time frame specified. If 0% of the objectives in a plan were attainable/realistic, this was coded as "None of the objectives are attainable and realistic." If 1-49% of the objectives in a plan were attainable/realistic, this was coded as "Some of the objectives are attainable and realistic." If 50-99% of the objectives were attainable/realistic this was coded as "Most of the objectives are attainable and realistic" and if 100% were, this was coded as "All of the objectives are attainable and realistic." From Time 1 to Time 4, the percentage of plans with all attainable/realistic objectives increased from 64% of plans at Time 1 to 79% of plans at Time 4. Units/clinics that received training/coaching tended to do better on this item compared to units/clinics that did not receive training. For example, at Time 3, 88% of plans from units/clinics that received training/coaching had all attainable/realistic objectives compared to only 65% of plans from units/clinics that did not receive training/coaching.

The interventions specify the frequency.

This item measures the percentage of interventions in a plan that specify the frequency – that is how often (e.g., weekly, monthly) interventions will occur. If 0% of the interventions in a plan specified how frequently an intervention would occur, this was coded as "none of the interventions specify the frequency." If 1-49% of interventions specified a frequency, this was coded as "Some of the interventions specify the frequency." If 50-99% specified a frequency this was coded as "Most of the interventions specify the frequency," and if 100% did so, this was coded as "All of the interventions specify the frequency." From Time 1 to Time 3, the percentage of plans with all interventions specifying the frequency increased slightly from 52% at Time 1 to 61% at Time 2 and Time 3. At Time 4, the percentage of plans with all interventions specifying the frequency fell to 39%, which likely reflects the fact that Time 4 only included ASH plans. There were not large differences between units/clinics that did and did not receive training/coaching on this item.

The interventions specify the number of units.

This item measures the percentage of interventions that specify the number of units – that is, the number of times an intervention would occur. If 0% of the interventions in a plan specified the number of units, this was

coded as “None of the interventions specify the number of units.” If 1-49% of interventions specified the number of units, this was coded as “Some of the interventions specify the number of units.” If 50-99% specified the number of units this was coded as “Most of the interventions specify the number of units,” and if 100% did so, this was coded as “All of the interventions specify the number of units.” From Time 1 to Time 3, the percentage of plans that specified the number of units for all interventions was fairly stable. For example, at Time 1, 29% of plans specified the number of units for 100% interventions compared to 36% of plans at Time 2 and Time 3. However, at Time 4, 0% of plans specified the number of units for all of plan interventions, which likely reflects differences between ASH and HC. There were not large differences between units/clinics that did and did not receive training/coaching on this item.

The interventions specify the duration.

This item measures the percentage of interventions that specify the duration – that is how long an intervention would last (e.g., one hour). If 0% of the interventions in a plan specified the duration, this was coded as “None of the interventions specify the duration.” If 1-49% of interventions specified the duration, this was coded as “Some of the interventions specify the duration.” If 50-99% specified the duration this was coded as “Most of the interventions specify the duration,” and if 100% did so, this was coded as “All of the interventions specify the duration.” From Time 1 to Time 3, the percentage of plans that specified the duration for all interventions was stable. For example, at Time 1, 43% of plans specified the duration for all interventions compared to 49% of plans at Time 2 and 46% at Time 3. However, at Time 4, 0% of plans specified the duration for all of plan interventions, which again likely reflects differences between ASH and HC. There were not large differences between units/clinics that did and did not receive training/coaching on this item.

The interventions specify the staff member responsible.

This item measures the percentage of interventions that specify the staff member responsible. If 0% of the interventions in a plan specified the staff member who was responsible, this was coded as “None of the interventions specify the staff member responsible.” If 1-49% of interventions specified the staff member responsible, this was coded as “Some of the interventions specify the staff member responsible.” If 50-99% specified the staff member responsible this was coded as “Most of the interventions specify the staff member responsible,” and if 100% did so, this was coded as “All of the interventions specify the staff member responsible.” From Time 1 to Time 3, the percentage of plans that specified the staff member responsible for all interventions was stable. For example, at Time 1, 73% of plans specified the staff member responsible for all interventions compared to 68% of plans at Time 2 and 79% at Time 3. However, at Time 4, 100% of plans specified the staff member responsible for all of plan interventions, which again likely reflects differences between ASH and HC. There were not large differences between units/clinics that did and did not receive training/coaching on this item.

The interventions specify the type of services to be provided.

This item measures the percentage of interventions that specify the type of service to be provided. If 0% of the interventions in a plan specified the type of service to be provided, this was coded as “None of the interventions specify the type of services to be provided.” If 1-49% of interventions specified the type of service to be provided, this was coded as “Some of the interventions specify the type of services to be provided.” If 50-99% specified the type of service to be provided this was coded as “Most of the interventions specify the type of services to be provided,” and if 100% did so, this was coded as “All of the interventions specify the type of services to be provided.” From Time 1 to Time 3, the percentage of plans that specified the type of services to be provided for all interventions was fairly stable. For example, at Time 1, 88% of plans specified the type of services to be provided for all interventions compared to 94% of plans at Time 2 and 78% at Time 3. However, at Time 4, only 19% of plans specified the type of services to be provided for all of plan interventions, which again likely reflects differences between ASH and HC. There were not large differences between units/clinics that did and did not receive training/coaching on this item.

The interventions specify the purpose/intent as it relates to the objectives.

This item measures the percentage of interventions that specify the purpose/intent as it relates to the objectives – that is, whether or not an intervention specifies how it helps to achieve the objective that it is linked to. If 0% of the interventions in a plan specified the purpose/intent as related to the objectives, this was coded as “None of the interventions specify the purpose/intent.” If 1-49% of interventions specified the purpose/intent as related to the objectives, this was coded as “Some of the interventions specify the

purpose/intent." If 50-99% specified the purpose/intent as related to the objectives this was coded as "Most of the interventions specify the purpose/intent," and if 100% did so, this was coded as "All of the interventions specify the purpose/intent." Over time, the percentage of plans that specified the purpose/intent of all plan interventions increased. At Time 1, only 13% of plans specified the purpose/intent for all interventions compared to 31% at Time 2 and 45% at Time 3 (this fell again to 36% at Time 4 which might reflect differences between ASH and HC). There were not large differences between units/clinics that did and did not receive training/coaching on this item.

The Recovery Plan incorporates actions/contributions by natural supports (friends, family peers and community).

This item measures whether or not a plan incorporates actions or contributions from natural supports – friends, family, peers (but not peer specialists), and the community. For example, the following is a typical ASH intervention incorporating contributions from natural supports: "Certified Family Partner will make contact with family members at least once prior to discharge to offer support to the family assisting them with self-advocacy in order to assist with transition supports in their local community." The following is an example of a HC intervention incorporating contributions from natural supports: "[person] will…complete homework with her family so they can all learn at the same time." This intervention also links back to an objective that also incorporates natural supports: "[person] will involve her family and friends in learning about bipolar disorder." The percentage of plans incorporating actions/contributions from natural supports was fairly stable from Time 1 to Time 4. At Time 1, 38% of plans incorporated actions/contributions from natural supports, compared to 34% at Time 2, 36% at Time 3, and 46% at Time 4. There were not large differences between units/clinics that did and did not receive training/coaching on this item.

Interventions include self-directed action steps based on the individual's strengths and identified interests.

This item measures whether or not a plan includes any self-directed action steps on the part of the consumer – that is, an activity within the plan interventions that a consumer would do on his/her own without any service providers. The following is an example of a HC intervention that includes a self-directed action step based on the individual's strengths and interests: "[person] will attend her weekly home ministry to practice learned job skills and continue to build a support network." The following is an example of an ASH intervention that includes a self-directed action step: "On a daily basis, nursing staff will offer structured activities for [person], possibly throwing the football outside in the courtyard or using the ping pong game in the rec area to continue working on his treatment and encouraging him on his progress." From Time 1 to Time 3, the percentage of plans incorporating self-directed action steps increased from only 3% at Time 1 to 22% at Time 3. At Time 4, only 3% of plans incorporated self-directed action steps, which likely reflects the fact that Time 4 only included ASH plans which were less likely than HC plans to incorporate self-directed action steps. Units/clinics that received training/coaching were somewhat more likely than units/clinics that did not receive training/coaching to include self-directed action steps. For example, at Time 3, 29% of plans from units/clinics that received training/coaching included self-directed action steps, compared to 17% of plans from units/clinics that did not receive training/coaching.

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 Legally Authorized Representative (LAR).

This item measures the number of plan elements that indicate the plan was developed in consultation with the consumer as evidenced by 1) quotes, 2) documentation of input from the consumer, and/or 3) signature from the consumer or LAR. Overall, none of the plans included all three of these elements because none of the plans included a signature from the consumer/LAR. Further, none of the HC plans included at least two of these elements because none of these plans explicitly stated that a consumer was involved in the development of the plan. From Time 1 to Time 4, the percentage of plans incorporating two of these elements increased from 20% at Time 1 to 36% at Time 3 and 81% at Time 4 (which reflects differences between ASH and HC plans). There were not large differences between units/clinics that did and did not receive training/coaching on this item.

Focus Groups

Accomplishments

Focus group participants were asked to reflect on accomplishments related to PCRP implementation. In total, participants named 95 distinct accomplishments. These accomplishments were sorted into the following nine categories:

1) Organizational and Cultural Shift to Recovery-Oriented Care
2) Better Care and Consumer Outcomes
3) Better/More Recovery-Oriented, Person-Centered Plans
4) Staff Buy-In/Commitment
5) Increased Consumer Engagement/Involvement
6) Treatment Team Dynamics: Every Member has a Voice and is Engaged
7) Clinician Growth
8) Peer Specialists are More Engaged with Consumers and More Person Centered
9) Peer Specialists have More Autonomy and Respect from Other Staff

Overall, focus group participants named more unique accomplishments related to organizational and cultural shifts, better care and consumer outcomes, and better plans. In contrast, focus group participants named fewer accomplishments related to peer specialists having more autonomy and being respected by other staff and clinician growth.

There were some differences in terms of the accomplishments that different focus group types (i.e., leadership, peer specialist, and practitioner groups) named. In particular, leadership focus group participants named more unique accomplishments related to providing better care and more positive consumer outcomes and staff buy-in/commitment to the PCRP process compared to peer specialist and practitioner participants. In contrast, peer specialist focus group participants named more unique accomplishments related to greater peer specialist engagement with consumers, peer specialists having more autonomy and being more respected by other staff members and fewer unique accomplishments related to writing better/more recovery-oriented, person-centered plans and clinician growth compared to leadership and practitioner participants. Practitioner participants name more unique accomplishments related to writing more recovery-oriented, person-centered plans. Finally, leadership and peer specialist focus group participants named more unique accomplishments related to organizational and cultural shifts to a recovery-oriented care compared to practitioner participants.

Barriers

Focus group participants were asked to reflect on barriers they have faced related to PCRP implementation. In total, participants named 111 distinct barriers. These barriers were sorted into 12 categories:

1) Staff Lack Knowledge, Training, and Confidence
2) Time and Resource Barriers
3) Change is Hard
4) Dissemination Barriers
5) Lack of Consumer Buy-In
6) Lack of Staff Buy-In
7) Software and Plan Structure Barriers
8) Leadership Barriers
9) State and Policy Barriers
10) Non-Collaborative Planning
11) Problems with Coaching, Training, and Technical Assistance
12) Unclear How to Apply PCRP to Different Types of Consumers

Overall, focus group participants named more unique barriers related to a lack of staff knowledge, training and confidence as well as a lack of time and resources. In contrast, focus group participants named the fewest barriers related to a lack of clarity on how to apply PCRP to different types of consumers.

There were some differences in terms of the barriers that different focus group types (i.e., leadership, peer specialist, and practitioner groups) named. In particular, practitioner focus group participants named more unique barriers related to a lack of consumer buy-in, software and plan structure issues, lack of collaborative

planning, and problems with coaching, training, and technical assistance compared to leadership and peer specialist participants. Peer specialist focus group participants, followed by practitioner participants, named more barriers related to a lack of staff buy-in compared to leadership participants. Leadership and practitioner focus group participants named more unique barriers related to a lack of time and resources compared to peer specialist participants. Finally, leadership and peer specialist focus group participants named more unique barriers related to the difficulty of change compared to practitioner participants.

Resources

Focus group participants were asked to discuss both the resources that had contributed to accomplishments related to PCRP implementation as well as resources that they need in the future to more successfully implement PCRP.

In terms of resources that had been helpful in implementing PRCP, focus group participants listed several resources from a variety of internal and external sources, as well as specific Via Hope resources that helped them to successfully implement PCRP. These are outlined below.

Helpful Via Hope Resources

Tools/Materials

- Assessment tools (e.g., form for technical assistance calls)
- Audit tool
- Materials (e.g., PowerPoints)
- Train the Trainer manual
- Family Partner Training for Supervisors of Family Partners, templates

Coaching/Training/TA:

- Coaching
- Coaching workshop
- Certified Peer Specialist training
- Technical Assistance
- Train the Trainer training
- Training, the quality and extensiveness

Expertise/Vision

- Expertise
- Being open to questions
- People (e.g., Janis, Diane, Lyn, Anna)
- Providing a fresh perspective/vision

Support/Follow-Up

- Support
- Constant follow-up
- Positive push
- Creating Opportunities for Discussion and Team-work

Helpful Miscellaneous Resources

Tools

- Audit tools
- Collaborative documentation tool

External Trainings

- Cultural competency training
- DLA 20s training
- ECPR training
- IMR training
- LGBTQQIA trauma-informed training
- WRAP facilitation training

Internal Training/Coaching/TA

- Face-to-face internal TA
- Internal training and coaching
- Internal UM billing training

Guidelines/Examples/Modeling How to Write Plans

- Examples of treatment plans
- Modeling how to write a plan
- PCRP guideline sheets

Feedback/Support from Colleagues/Supervisor

- Feedback from supervisor
- Support from colleagues

In terms of resources or changes needed to continue to improve PCRP implementation, focus group participants provided several recommendations for both their employer organization and Via Hope.

Organizational Resources Needed

Training

- Incorporate PCRP into New Employee Orientation
- Offer the Training Academy to all staff, not just staff hired through 1115 Waiver Projects
- Ensure PCRP training is offered to newly hired clinicians
- Training on how to re-engage individuals who are not engaged or who are unable to identify barriers, strengths, goals, etc.

Coaching

- Coaches from both long- and short-term units
- Coaches from multi-disciplinary backgrounds
- Coaches who work closely with the team
- Institute a coaching program
- Coaches should provide concrete feedback
- Using supervisors as coaches to limit anxiety experienced by practitioners on the TA calls
- Training/designating more coaches

Software and Billing

- Align software with PCRP
- Allowing to bill for planning – more time would be spent upfront, which would help with hours, enhance services, and simplify documentation of services

Staff

- Physician buy-in, participation, and engagement
- Hiring more peer specialists; obtaining funding for peer support positions
- Peer specialist involvement in planning
- Involving peer specialists in intake
- Getting plan to front-line/direct care staff
- Address staff resistance
- Address scheduling and communication issues
- Using information obtained during intake when consumers aren't ready to open up or are in crisis

Dissemination

- Creating a PCRP taskforce
- Implementing PCRP throughout the organization

Via Hope Resources Needed

PCRP-Specific Training

- Linking plan components
- Writing achievable objectives
- Creating simplified treatment plans suitable to provide to consumers
- Writing narrative summaries (provide feedback earlier in process)
- Modeling how to write a plan; sample/example treatment plan; technical information on writing a plan
- More frequent trainings and/or refreshers
- Billing for PCRP
- Enhancing the training for Behavioral Health Directors
    - Involve Janis and Diane to 'pump up' attendees
    - Show how PCRP ties into outcomes
- Connecting PCRP to other projects and initiatives

Training on How to Expand PCRP

- Crisis populations
- Level of Care 1
- Children and families
- PCRP for peer specialists

Training not specific to PCRP

- Working as a multidisciplinary team
- Teaching sites how to serve as consultants to other organizations attempting to implement PCRP
- Trauma-informed training
- Training for practitioners on the value of integrating peer specialists in planning meeting
- Demystifying peer support for clinicians
- Mental Health First Aid
- WHAM
- Whole Health Resiliency Training
- WRAP training
- Collaborative documentation
- Providing information about trainings and other resources

Coaching and TA Calls

- Offer a coach-the-coach training
- Opportunity to revise the same plan multiple times for TA calls
- Clarify purpose of TA calls
- Provide consistent information on TA calls
- Wording requirements on coaching calls should be less specific
- Integration of DSHS and TA Call Summary Form

Ongoing Via Hope Support

- Maintaining a contractual relationship between Via Hope and participating organizations
- Continuing to provide evaluation and monitoring support

Summary of Findings

Accomplishments

Better Relationships between Staff and Consumers

Survey data and focus group data both indicate that PCRP implementation has resulted in better relationships between staff and consumers. For example, when consumers were asked to indicate the best part of the recovery planning process they reported the following: support from staff, talking to staff, and better relationships with staff. This theme was reiterated in the focus groups. For example, a respondent in the ATCIC practitioner group noted: "Just developing that rapport and relationship with our clients to make them comfortable enough to even want to talk to us on a consistent basis. And I guess that's just again putting the ball in their court and letting them know that their info matters, we're just here to help you maneuver through this process."

More Consumer Involvement in Planning

Survey data and focus group data both indicate that PCRP implementation has resulted in more consumer involvement in planning. For example, when staff were asked to indicate the best part of the recovery planning process, nearly 40% of the staff who responded to this question reported consumer involved in planning, while another 15% reported that the best part of the recovery planning process was that consumers were in the driver's seat of their recovery. This theme also came up in the focus groups (see focus group accomplishment #2: increased consumer engagement/involvement). For example, one respondent from the ATCIC practitioner focus group explained that since PCRP implementation, consumers have had more control over their recovery planning: "Just people…really considering more of what the client wants versus what's…even with our medical side…it's just become more collaborative…it's not about what we think is going to make their goals happen, it's what they think is going to make their goals happen and even if we think their goals are these crazy outlandish things that are probably never going to happen, you know, us having the insight to recognize that some of those interventions, and objectives, and steps to reaching their goal that we don't agree with are still going to be really beneficial, great things." However, when both staff and consumers were asked to indicate ways to improve the planning process, they both reported that even more consumer involvement would improve the planning process.

Better Consumer Outcomes

Survey data and focus group data both suggest that PCRP implementation has resulted in better consumer outcomes. For example, when staff and consumers were asked to indicate the best part of the recovery planning process, 23% of consumer respondents and 19% of staff respondents reported better consumer outcomes. This theme also came up in the focus groups (see focus group accomplishment #1). For example, when asked about accomplishments related to PCRP, one respondent from the HC leadership group said: "If you focus on the individual served you'll see it. I had somebody come in yesterday and…she was smiling more and I asked her, I said 'I've seen you for years and I see you smiling more' and she actually pointed out some of the things that were on her treatment plan that were really successful for her. And I was like 'Ok, that's great!'"

More Individualized Plans

Survey data indicate that staff reported that one of the best parts of the recovery planning process is the implementation of individualized recovery plans. This finding is supported by focus group results; participants in the leadership, practitioner, and peer specialist focus groups all reported that since PCRP implementation, plans have become more individualized. For example, a focus group participant from the ASH leadership group explained: "Making plans much more person-specific and individualized and I think that it's possible because leadership has made a commitment to the philosophy and provides support to the recovery program manager. And then just training for everyone and coaching so that there's the implementation and providing feedback to individuals in the staff." While not addressed by an item on the Plan Review Tool, researchers did notice that plans became more individualized and person-centered over time and tended to rely less on drop-down menus and copy-and-paste functions when developing a plan.

Components of Plan Align

The review of HC and ASH plans suggest that one key way that person-centered recovery plans have improved over time is that the different components of plans are more likely to align. In particular the review suggests that: 1) recovery goals and objectives are more likely to link back to the narrative/integrated summary; 2) objectives are more likely to clearly link back to barriers/issues identified either in the narrative/integrated summary, weaknesses/issues, and/or problems/barriers sections; and 3) interventions are more likely to specify the purpose as related to the objectives. These findings were supported by focus group data. For example, a focus group participant from the HC leadership group described how components of plans are more likely to align since PCRP implementation: "Strengthening the medical necessity throughout the plan…just through learning how to do the clinical summary and writing the hypothesis and then carrying that down throughout the plan…And developing objectives around that and interventions that support and help reach those recovery goals."

Better Recovery Goals

Data from surveys, plan review, and focus groups all indicate that since PCRP implementation, plans are more likely to include better, more meaningful recovery goals. PCCQ data reveal that both staff and consumers reported that including meaningful life goals was one of the most commonly carried out person-centered practices. Survey data that asked staff the best part of the recovery process indicated that one of the most common responses was a focus on the consumer's goal(s). Plan review findings also revealed that, over time, plans were more likely to incorporate meaningful recovery goals that exist outside of the mental health system and that were written in the person receiving services' own words. These findings were also supported by our focus group findings. For example, a focus group participant from the ASH leadership group elaborated on writing more meaningful and individualized recovery goals: "I'm not seeing as many goals that are just…like 'I will take medications' or 'I want to stay out of the hospital,' 'I should stop drinking,' you know things like that. They're phrasing goals in terms of desired life outcomes, which is beautiful."

Better Objectives

Another key accomplishment is that objectives improved in several ways. Namely, plan review data suggest that over time objectives were more likely to specify due dates and more likely to be behavioral, measurable, and attainable/realistic. These findings also supported by focus group data. For example, a focus group participant from the ATCIC practitioner group elaborated on writing better objectives: "I usually ask them if they have something that they want to keep doing that's working well for them…finding what they enjoy, their current strengths…like setting objectives that a client actually wants you to print out and check in on…like objectives that are helpful. And usually you're able to do that if it's like very specific and if it starts out slow…so something…don't set it really high so they'll feel pressured to do all this stuff. Like, walk one time a week instead of five times a week."

Areas for Improvement

Access to and Utilization of Peer Specialist Services

Survey data and focus group data both indicate the need for greater access to and utilization of peer specialist services. For example, PCCQ data indicate that consumers reported that having the opportunity to work with a peer specialist is one of the least frequently implemented person-centered practices at their organization. Survey data also indicate that while 66% of consumer respondents reported that they have the opportunity to work with a peer specialist, only 36% of respondents reported that actually do. This theme of underutilization of peer support services also came up in the focus groups. For example, respondents from peer specialist focus groups reported that recovery coaches and doctors rarely invite peer specialists to planning meetings. One respondent from the HC peer specialist focus group explained: "They'll [recovery coaches] call us in to engage people, but then when they actually go do the PCRP, they're not calling us in. I'm not sure how some of them see us playing that role maybe? I don't know what they learned in their training on that end, but maybe they're thinking 'Oh I just need to do this, why do I need them in here? What's that gonna help, or it's just gonna waste my time or…'…there's only one that's really inviting me in. And I know it can't be mandatory that they have us because it's up to the client first and foremost, but it might ought to be higher on the list of trying to incorporate us."

Actively Using Strengths/Individualized Strengths

From Time 1 to Time 4, plans were more likely to actively incorporate individuals' strengths. However, overall only 15% of plans did so, suggesting a key area for improvement. One reason that strengths may not have been more actively incorporated into plans is that plan writers were often relying on drop-down menus that limited their ability to include individualized strengths and individualized strengths lend themselves more readily to being actively incorporated into plans. Thus, this issue may be partially linked back to barrier #6 from the focus group findings: software and plan structure barriers. For example, one focus group participant from the HC practitioner group explains: "I think it's odd for me on the PCRP that…the strengths includes the drop-down box and then the barriers doesn't. And I'm trying to decide is it helpful…I think it's helpful because maybe it gives you ideas but then it goes back to that cookie cutter thing where people are putting the same thing every time: 'verbalize feelings,' 'motivation for treatment.' … I don't know if that's a good thing or a bad thing. I find myself with the strengths doing a lot of 'other,' so that way I'm not just putting things are just on the drop-down box."

Addressing Culture

Another key area for improvement is identifying and addressing cultural issues in plans. Only 5% of plans both identified and addressed cultural issues. Focus group results suggest that even when practitioners are aware that cultural issues matter, they may be unclear about how to address those issues in plans. That is, practitioners may lack knowledge, training, and confidence (focus group barrier # 4) about addressing cultural issues. As one focus group participant from the ATCIC peer specialist group explains: "Well even what the racial issues mean or how they come out, you know, like privilege and things like that…it's the other part of the racial issue. There's a disconnect in my opinion, you know 'Ok well we're aware of the fact that, you know, skin color matters,' and things like that…like upbringing and what not…but what does that really mean? What does that look like? How does that play out in real life for each person? You know?"

Addressing Trauma

Another key area for future training and coaching efforts involves effectively addressing trauma. Although about 29% of plans identified trauma, only 4% of all plans addressed trauma. Not only is it likely that a great deal of trauma is not being identified, but even when identified plan writers rarely address trauma. This may stem from a lack of trauma-informed training (focus group barrier #4) as one focus group participant from the ASH peer specialist group suggested: "It would have been nice I think if maybe…the trauma-informed training could have been part of the PCRP. You know, that that could have been integrated somehow." However, another focus group participant from the ASH peer specialist group noted that although ASH was starting to prepare a trauma-informed care implementation training, a lack of staff buy-in (focus group barrier # 3) might hinder the success of this training: "Still the main problem is getting every other group to buy in to it. You know? Like from the doctors to the social workers to the nurses and stuff. And it seems like you gotta get at least one of those groups to buy in to it before it's ever gonna make any difference."

Natural Supports

Another key theme from the data is that natural supports could be more involved in the planning process and recovery journey. For example, PCCQ data reveal that both consumers and staff say that reminding consumers to bring natural supports to the planning meetings is one of the least frequently carried out person-centered practices. This theme was also echoed in the focus groups; for example, one respondent from the HC leadership group suggested that high caseloads may be a barrier to reminding consumers to bring natural supports to planning meetings: "I think that's kind of part of the challenge though for folks that are in level of care 1 for the staff to really be thoughtful about who's going to need their recovery plan reviewed in the coming weeks and let me call them and tell them that it's coming up and give them an opportunity to bring somebody cause it's like they get into their appointment and the recovery coach realizes their plans needs to be done…I mean you know what I mean? When you've got however many that you're working with … 250 [people]…it's hard to keep up with I think."

Further, the plan review data reveal that only 37% of plans incorporated actions/contributions from natural supports and that from Time 1 to Time 3, plans did not improve in terms of incorporating natural supports (a slightly higher percentage of plans incorporated natural supports at Time 4 which only included ASH plans). Thus, future coaching and training efforts should focus on incorporating natural supports more often as well as in more meaningful and individualized ways. For example, although about half of all ASH plans incorporated

actions/contributions from natural supports, most did so in a standardized social work intervention that specified contact with "involved family" regarding aftercare planning.

Self-Directed Action Steps

From Time 1 to Time 3, plans were much more likely to incorporate self-directed action steps based on individuals' strengths and identified interests. This finding was supported by PCCQ survey data wherein consumers reported that one of the most frequently carried out person-centered practices was the inclusion of self-directed action steps in the plan. However, only 12% of all plans that we reviewed incorporated self-directed action steps into interventions. Therefore, future training and coaching efforts should focus on incorporating more self-direction action steps into recovery plans.

Evidence of Individual's Participation in the Recovery Planning Process

Another area for improvement is providing better evidence that the person receiving services participated in the recovery planning process. Specifically, future training and coaching efforts should focus on incorporating multiple indicators that the plan was developed in consultation with the person receiving services, including but not limited to: quotes from the person, a signature from the consumer or legally authorized representative, and documentation that the person attended his/her planning meeting and was involved in developing the plan.

RECOMMENDATIONS

Via Hope

Person-Centered Planning Practices

- Shift the focus to internal coaching/training earlier in the process so organizations are building internal capacity and take more ownership in the process
    - Will likely reduce Via Hope staff time spent preparing for and delivering training and coaching sessions
- Provide opportunities or encourage staff to educate consumers on the benefits of participating in peer support/working with a peer specialist
- Provide training on addressing various cultural issues
- Highlight the importance of addressing trauma
- Provide training on trauma-informed care and how to address trauma in PCRP

Person-Centered Recovery Plans

- Encourage practitioners/coaches to look for more opportunities to include natural support actions in plans in meaningful ways (not in "canned" ways such as including them in aftercare planning)
- Provide training on how to actively incorporate strengths into plans
- Provide training on how to address cultural and trauma-related issues in plans
- Encourage sites to use the plan as a working document and not just for billing

Program Development

- Provide coaching/training/TA on the planning process earlier on in the project. Once person-centered planning processes are in place, switch focus of support to plan document – help providers identify ways in which person-centered planning processes are reflected/not reflected in plan documents while also ensuring plans meet billing/accrediting requirements
- Identify evidence-based implementation guidelines that align with the goals of the program and structure the program around selected framework/guidelines
    - Providing more structure and focus to the program will allow evaluators to develop measures to assess program outcomes at both the organizational and consumer level. Positive findings associated with the program may be leveraged to market the program to other organizations and secure additional funding.
    - Offer well-rounded approach to implementation by focusing on several domains of implementation. The pilot program focused primarily on coaching and training and did not address other aspects important to successful implementation, such as leadership, facilitative administration, data systems, etc.

- Set up feedback loops to regularly check in with staff and consumers to obtain feedback on ways to improve the planning process and help organizations work through barriers as they arise
- Be aware of and monitor implementation fatigue and adjust technical assistance accordingly
- Plan a final event to wrap up the program – celebrate successes, congratulate organizations for their dedication to the process, address any outstanding issues, cultivate a PCRP community

Department of State Health Services

- Offer DSHS staff training on PCRP to enhance understanding of and the value of person-centered practices
- Work with organizations to determine ways to be reimbursed for recovery planning
- Allow organizations to bill for the planning process
- Allow organizations to bill for peer support or other services without a treatment plan in place first
- Conduct a cost-benefit analysis to determine cost savings associated with person-centered recovery planning. If proven to be cost-effective, dedicate more funding to person-centered care
- Provide funding for organizations to hire more peer specialists
- Encourage organizations to hire more trauma care providers and encourage organizations to adopt a trauma-informed care perspective
- Work with organizations to tailor electronic medical record templates so that they align with person-centered practices
    - Discourage the use of drop-down menus in electronic medical record
- Fund evaluation efforts to conduct a more in-depth review of recovery plans in order to revise the plan review tool to better assess the person-centeredness of plans (many items do not measure person-centered)

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Appendix A:
Changes to the PCRP Quality Improvement Review Tool

PCRP Quality Improvement Review Tool Item 1

This item was modified to measure whether or not the recovery goals and objectives match the narrative/integrated summary because comprehensive assessments were not provided to the researchers.

Original Item:

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

Yes
No

Modified Item:

The recovery goals and objectives are linked to the integrated/narrative summary.

Yes
No

PCRP Quality Improvement Review Tool Item 4

The response choices from this item were modified because they neither mutually exclusive nor exhaustive and did not sufficiently address the double-barreled nature of the item (i.e., that the item measures both whether the problems/barriers are linked to goals and whether problems/barriers address mental health/substance use issues).

Original Item:

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

Modified Item:

The Recovery Plan includes a description of the presenting problem/barriers to goal attainment as a result of the mental health or substance use issues.

2 =Problem/barrier is linked to goal AND addresses mental health or substance use issues
1 = Problem/barrier is linked to goal OR addresses mental health or substance use issues, but not both
0 = Problem/barrier IS NOT linked to goal AND DOES NOT address mental health or substance use issues

We also replaced substance “abuse” issues with substance “use” issues to be more recovery-oriented and to align with SAMHSA language.

PCRP Quality Improvement Review Tool Item 5

This item was modified to measure the percentage of objectives in a plan with target dates, rather than the percentage of goals, objectives, and interventions with target dates. The change was made in order to make this item more meaningful (rarely did plans include target dates for all goals, objectives, and interventions) and to match the response choices which only address objectives. We also changed answer choice “1” to read “some of the objectives specify the target date” instead of “some of the objectives DO NOT specify the target date.”

Original Item:

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

Modified Item:

The Recovery Plan includes the expected date by which the objectives 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 specify the target date
0 = None of the objectives specify the target date
All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0

PCRP Quality Improvement Review Tool Item 6

This item was modified to include a "not applicable" response choice to account for plans that had only one objective or plans that had only one objective with a specified target date.

Original Item:

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

Modified Item:

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
N/A = Not Applicable (only one objective or only one objective with a target date)
All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0

PCRP Quality Improvement Review Tool Item 13

The original item measured the percentage of plan objectives that could be linked back to barriers/issues identified in the comprehensive assessment. However, because researchers did not have access to all comprehensive assessments for all years, the item was modified to measure the percentage of plan objectives that could be linked back to barriers/issues identified in the narrative/integrated summary, desired result for recovery, weaknesses, problems/barriers, issues/needs, and/or unique needs section of the plan.

Original Item:

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

Modified Item:

The objective(s) can be linked back to barriers and issues identified in the narrative/integrated summary, desired result for recovery, weaknesses, problems/barriers, issues/needs, and/or unique needs section.

3 = All of the objectives can be linked to barriers/issues identified in the narrative/integrated summary, desired result for recovery, weaknesses, problems/barriers, issues/needs, and/or unique needs section
2 = Most of the objectives can be linked to barriers/issues identified in the narrative/integrated summary, desired result for recovery, weaknesses, problems/barriers, issues/needs, and/or unique needs section
1 = Some of the objectives can be linked to barriers/issues identified in the narrative/integrated summary, desired result for recovery, weaknesses, problems/barriers, issues/needs, and/or unique needs section
0 = None of the objectives can be linked to barriers/issues identified in the narrative/integrated summary, desired result for recovery, weaknesses, problems/barriers, issues/needs, and/or unique needs section
All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0

PCRP Quality Improvement Review Tool Item 14

This item was modified because the response choices were not clearly linked to the item – the response choices assessed the percentage of objectives that were clearly stated and not limited to receipt of a service, while the item assessed the percentage of objectives that addressed observable changes in behavior, functioning, or skills. Therefore this item was simplified and the response choices were modified to measure the percentage of plan objectives that described behavioral changes.

Original Item:

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

Modified Item:

The objectives describe behavioral changes.

3 = All of the objectives describe behavioral changes
2 = Most of the objectives describe behavioral changes
1 = Some of the objectives describe behavioral changes
0 = None of the objectives describe behavioral changes
All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0

PCRP Quality Improvement Review Tool Item 17

The original item measured five different intervention characteristics simultaneously (frequency, number of units, duration, staff member responsible, and type of services to be provided) and because rarely did an intervention include all five of these characteristics most plans would have scored a zero on this item if it had not been modified. Therefore, this item was broken into 5 separate questions, yielding a more comprehensive understanding of each of these characteristics.

Original Item:

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

Modified Items:

The interventions specify the frequency.

3 = All of the interventions specify the frequency
2 = Most of the interventions specify the frequency
1 = Some of the interventions specify the frequency
0 = None of the interventions specify the frequency
All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0

The interventions specify the number of units.

3 = All of the interventions specify the number of units
2 = Most of the interventions specify the number of units
1 = Some of the interventions specify the number of units
0 = None of the interventions specify the number of units
All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0

The interventions specify the duration.

3 = All of the interventions specify the duration
2 = Most of the interventions specify the duration
1 = Some of the interventions specify the duration
0 = None of the interventions specify the duration
All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0

The interventions specify the staff member responsible.

3 = All of the interventions specify the staff member responsible
2 = Most of the interventions specify the staff member responsible
1 = Some of the interventions specify the staff member responsible
0 = None of the interventions specify the staff member responsible
All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0

The interventions specify the type of services to be provided.

3 = All of the interventions specify the type of services to be provided
2 = Most of the interventions specify the type of services to be provided
1 = Some of the interventions specify the type of services to be provided
0 = None of the interventions specify the type of services to be provided
All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0

PCRP Quality Improvement Review Tool Item 18

This item was modified because the response choices were not clearly linked to the item – the response choices assessed the percentage of interventions that specify the purpose/intent of the services to be provided while the item assessed the percentage of interventions that specify the purpose/intent *as it relates to the Recovery Plan goals and objectives*. The researchers determined that it is more important for the interventions to link back to the objectives than it is to state the general purpose/intent of the service and the item and response choices were modified accordingly.

Original Item:

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

Modified Item:

The interventions specify the purpose/intent as it relates to the objectives.

3 = All of the intervention specify the purpose/intent of services to be provided as it relates to the objectives.
2 = Most of the interventions specify the purpose/intent of services to be provided as it relates to the objectives.
1 = Some of the interventions specify the purpose/intent of services to be provided as it relates to the objectives.
0 = None of the interventions specify the purpose/intent of services to be provided as it relates to the objectives.
All = 100%; Most = 50% -99%; Some = 1%-49%; and None = 0

Additional Item

Researchers also added an additional item to assess whether cognitive, intellectual, and/or developmental disabilities were identified and addressed in the plan.

Item:

If cognitive, intellectual, or developmental disabilities are identified, they are addressed in the Recovery Plan unless a clear rationale is provided for deferring issues from the Recovery Plan.

Yes
No
N/A