

# DSHS Grand Rounds



Presenters:  
Anna Jackson, Deputy Director, Via Hope, Univ. of Texas at Austin  
Diane Grieder, MEd, CEO, AliPar, Inc.  
Tracy Abzug, LCSW, Recovery Program Manager, Austin State Hospital

## Logistics

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## Logistics (cont.)

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3

## Disclosure to the Learner

### Requirement of Learner

Participants requesting continuing education contact hours or a certificate of attendance must register in TRAIN, attend the entire session, and complete the online evaluation within two weeks of the presentation.

### Commercial Support

This educational activity received no commercial support.

### Disclosure of Financial Conflict of Interest

Diane Grieder has shared that she serves as President of *AliPar* consulting firm and receives royalties from Elsevier Publishing.

Planning committee members have disclosed no relevant financial relationships.

### Non-Endorsement Statement

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4



David Lakey, MD  
DSHS Commissioner  
is pleased to introduce today's  
DSHS Grand Rounds speakers

5

## Faculty



Anna Jackson, MSSW  
Via Hope



Diane Grieder, MEd  
AliPar, Inc.



Tracy Abzug, LCSW  
Austin State Hospital

6

## Learning Objectives

- Describe three basic principles of the recovery model.
- List four elements of Person Centered Recovery Planning (PCRP).
- Describe the strategies for implementation of PCRP at Austin State Hospital.
- Identify at least two successes achieved during initial implementation.
- Identify at least two barriers encountered during implementation and corresponding strategies used to overcome them.

7

## Agenda

- Via Hope: Background, History Context
- Person Centered Recovery Planning: An Introduction to Recovery, the PCP Model, and Putting Theory into Practice
- PCRP in Practice: Austin State Hospital
- Discussion

8



## Via Hope: Background, History, Context

Anna Jackson, Deputy Director  
 anna.jackson@viahope.org  
 www.viahope.org



9

## Via Hope's Roots

- Texas Mental Health Transformation Grant (SAMHSA)
  - Consumer and Family Voice Subcommittee
  - Est. Via Hope in 2009
- Currently funded by Texas DSHS and the Hogg Foundation
- Part of The University of Texas at Austin Center for Social Research, Texas Institute for Excellence in Mental Health
 

Major Initiatives:

  - Recovery Institute (Next Slides)
  - Peer Specialist Training and Certification
  - Family Partner Training and Certification
  - Transition Age Youth Initiative
  - Peer-Run Organization Project



10

## Via Hope Collaborative Learning Projects

### FY2010: Peer Specialist Learning Community

- Designed to encourage/facilitate use of peer specialists
- 10 LMHCs, 1 Peer-Run Organization

### FY2011: Recovery-Focused Learning Community

- Designed to encourage re-orientation of philosophy to recovery focus and highlighted importance of peer support in recovery model
- 5 Hospitals, 10 LMHAs

### FY2012: Launched the Recovery Institute

- Awareness building, Leadership Academy, Peer Specialist Integration, Person-Centered Recovery Planning (22 total organizations)



11

## Via Hope Recovery Institute



For more information, contact Anna Jackson, Deputy Director of Via Hope  
[anna.jackson@viahope.org](mailto:anna.jackson@viahope.org)

12

## FY 2014-2015 Recovery Institute Application

- Application opened October 23<sup>rd</sup> after informational webinar. Closes November 22<sup>nd</sup>.
- Peer Specialist Integration Project, Leadership Academy, and Awareness Raising Projects open for applications.
- Projects go from January, 2014 to June, 2015.  
For more information, go to  
[www.viahope.org/recovery-institute](http://www.viahope.org/recovery-institute).



13

## Person-Centered Recovery Planning



PCRP is the most intensive *systemic* intervention in the Recovery Institute as well as a recovery-oriented practice that directly reaches people receiving services, requiring organizations to change their practices and individual practitioners to learn new skills.

14

## PCRP Pilot Team/Partners

- Coordinated by Via Hope.
- Funded by Texas Department of State Health Services
  - Partnership with Mental Health Transformation & Operations, Quality Management.
- Evaluated by The University of Texas Center for Social Work Research Institute for Excellence in Mental Health.
- Consultation by Yale Program for Recovery and Community Health and Alipar, Inc.
- Pilot Sites:
  - Austin State Hospital, Bluebonnet Trails Community Services, Hill Country MHDD, Austin Travis County Integral Care.

15

## PCRP Pilot Overview

- Most intensive of Recovery Institute initiatives
- Launched January, 2012 (first two sites) and entered second phase in October, 2012 (added two sites, moved to new units at original sites)
- On-Site Skills Training
- Tailored Technical Assistance Visits
- Individual, Plan-Focused Coaching Calls
- Leadership/System Strategy Calls
- Trainer and Coach Development
- Multidisciplinary Support
  - Clinical Staff
  - Peer Specialists
  - Administration/ Leadership

16

## What Have We Learned?

- Person-centered practices +
- Recovery focus +
- Removing organizational barriers +
- Practicing skill building +
- Clinical Supervision and PCP Coaching +
- Quality Improvement/Data +
- Leadership = real change and implementation of person-centered planning.

*Evaluation of this project is provided by the Texas Institute for Excellence in Mental Health at The University of Texas at Austin.*

17

17

The original pilot sites have spread to new units, and the two new sites began implementation this past winter. The TA strategy used has been intense, but effective.

18

DSHS MHSA Quality Management Team has developed a new treatment plan review tool that aligns Texas regulations with PCRP quality measures. They have partnered with the PCRP consulting team and pilot sites.

DSHS is also developing a broadcast to communicate about recovery-oriented transformation activities, and their alignment with other changes in the landscape.

19

Diane Grieder, M.Ed., Alipar, Inc. [diane@alipar.org](mailto:diane@alipar.org)

## **PERSON-CENTERED PLANNING: THE MODEL**

20

## Traveling the Transformation Highway



21

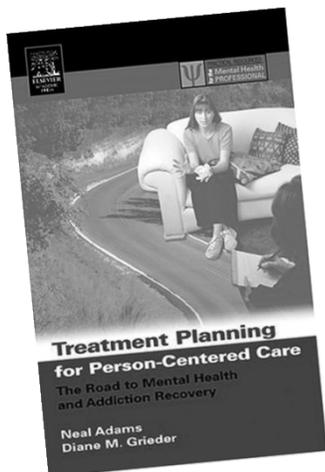
## Recovery...a Fuzzy Concept

- **everyone recognizes overall meaning**
  - different connotation for different people
- **core elements of concept are clear**
  - but unclear on the periphery
- **difficult to operationalize in measurable elements**



22

# What is PCR/P?



## Person-centered planning

- is a collaborative process resulting in a recovery oriented treatment plan
- is directed by consumers and produced in partnership with care providers and natural supporters
- supports consumer preferences and a recovery orientation

Adams/Grieder

23

Adams  
Grieder

Second Edition

Treatment Planning  
For Person-Centered Care

**Treatment Planning for Person-Centered Care, second edition** guides therapists in how to engage clients in building and enacting collaborative treatment plans that result in better outcomes. Suitable as both a reference tool and as a text for training programs, the book provides practical guidance on how to organize and conduct the recovery plan meeting, prepare and engage individuals in the treatment planning process, help with goal setting, use the plan in daily practice, and how to evaluate and improve the results. Case examples throughout help clarify information applied in practice and sample documents illustrate assessment, objective planning, and program evaluation.

The 2nd edition of Adams/Grieder *Treatment Planning for Person-Centered Care* retains the excellent content and voice that has made the first edition an important contribution to clinical service delivery. The new edition offers an outstanding revision of the opening chapter to explain the new policy context for person-centered care, particularly addressing changes in thinking about recovery and in practice due to the implementation of the Affordable Care Act and the introduction of the DSM 5.

— Howard H Goldman, M.D. Ph.D., Director of the Behavioral Health Systems Improvement Collaborative, University of Maryland School of Medicine

Easy to read book that explains both the "why" and the "how" of patient centered planning. Adams and Grieder, long time experts in the treatment of people with serious mental illness, connect the timeless concepts of shared decision making and patient centered treatment to the future of health care. Parity and the Affordable Care Act makes treatment more accessible, this book helps to ensure treatment is effective. —Linda Rosenberg, President and CEO, National Council for Behavioral Health

This new edition of Person Centered Planning provides an update and upgrade to what was already an essential read for people associated with systems transformation in behavioral health care. New material related to the impact of the Accountable Care Act and parity legislation give it even more relevance for these processes. Adams and Grieder provide a blueprint for what person centered care could and should be as we move into the future. Improved case examples that are referenced throughout the text illustrate the major principles developed in the book and allow readers to translate theory to practice more easily. Overall, this edition represents a significant elaboration of the original which makes it well worth reading, even for those who have already enjoyed the first edition. —Wesley Sowers, MD, Director, Center for Public Service Psychiatry, Western Psychiatric Institute and Clinic

**Treatment Planning for Person-Centered Care**  
Shared Decision Making for Whole Health

Second Edition  
Neal Adams and Diane M. Grieder

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store.elsevier.com

ISBN 978-0-12-394448-1

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**Treatment Planning for Person-Centered Care**  
Shared Decision Making for Whole Health

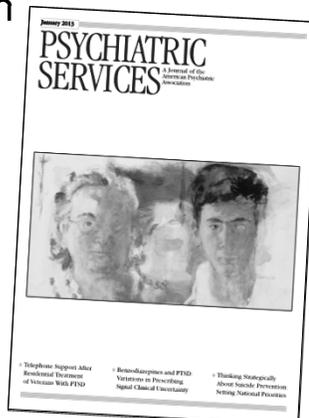
Second Edition

Neal Adams  
Diane M. Grieder

## Why Bother?

Person-centered recovery planning and collaborative documentation were associated with greater engagement in services & higher rates of medication adherence

Psychiatric Services 64:76–79, 2013



25

## The Recovery Plan as a Contract

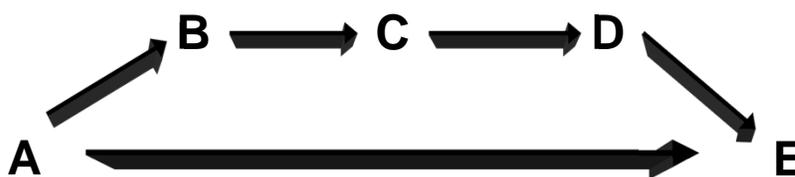


It is the “work contract” created by the person and provider.

26

## The Recovery Plan as a Road Map

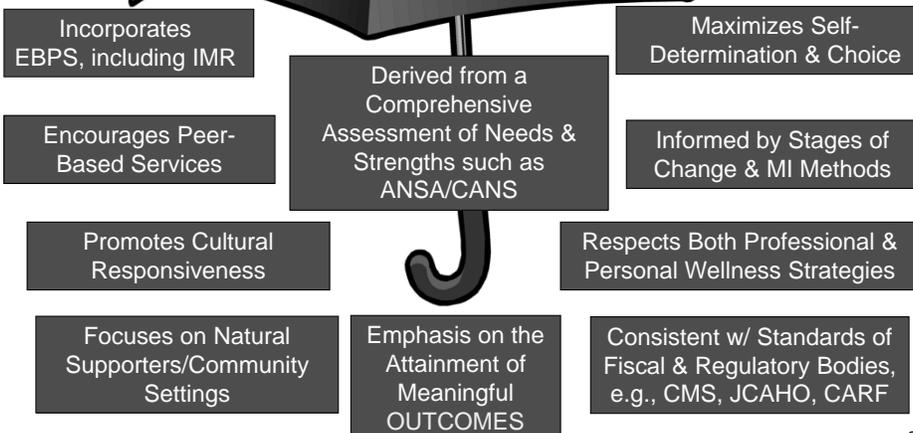
Provides hope by breaking a seemingly overwhelming journey into manageable steps for both the provider and the person served.



*"life is a journey... not a destination"*

27

## The Person-Centered Plan as an Integrating Framework for Quality in a Changing Healthcare Climate



28



## Simple Truth #1

- Person-Centered planning (PCP) is what people want.

*"Nearly every consumer of mental health services expressed the need to fully participate in his or her plan for recovery."*

-The 2003 President's Commission on Mental Health

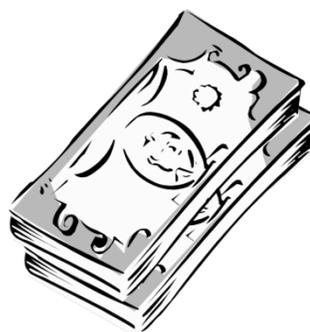
- Research shows we traditionally **underestimate** consumers' desire and willingness to partner in their care planning

-Chinman, et al., 1999

29

## Simple Truth #2

- Service providers and service agencies rely on payors (Medicaid, Medicare, Managed care programs) to survive.
- PCRP must attend to medical necessity.



30

## Simple Truth #3

Most people in this world are generally doing the best they can with what skills they possess at the moment.



31

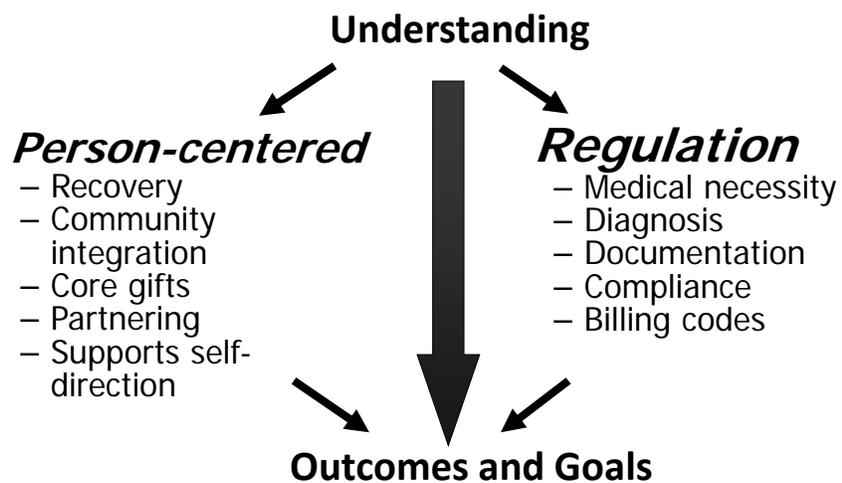
## Simple Truth #4

Many administrators and practitioners feel stuck between a rock and a hard place... as they struggle to reconcile (seemingly) competing tensions.



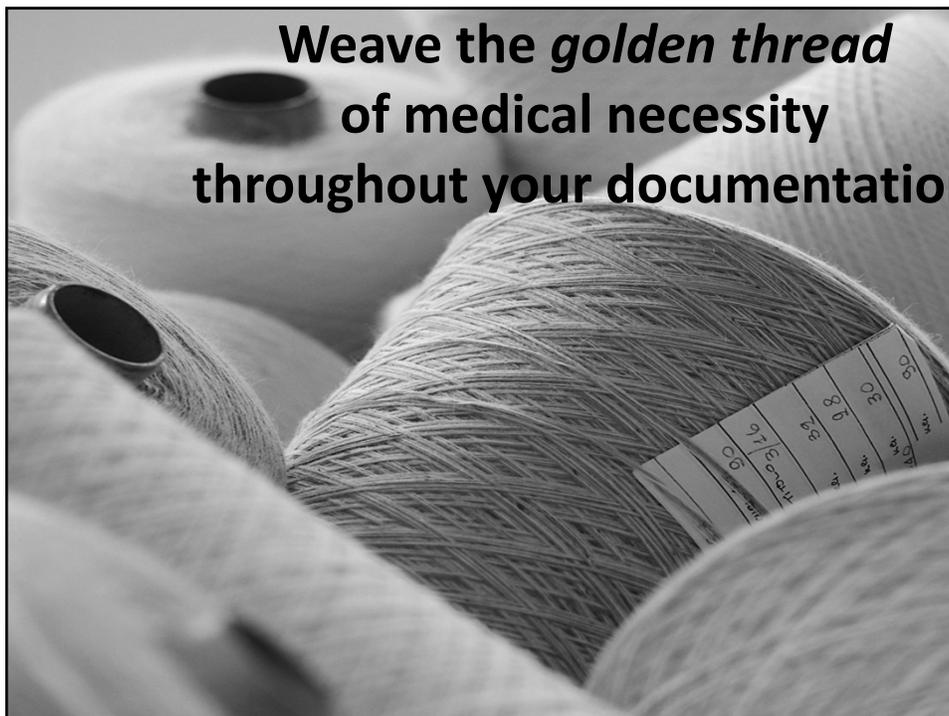
32

## Serving Two Masters

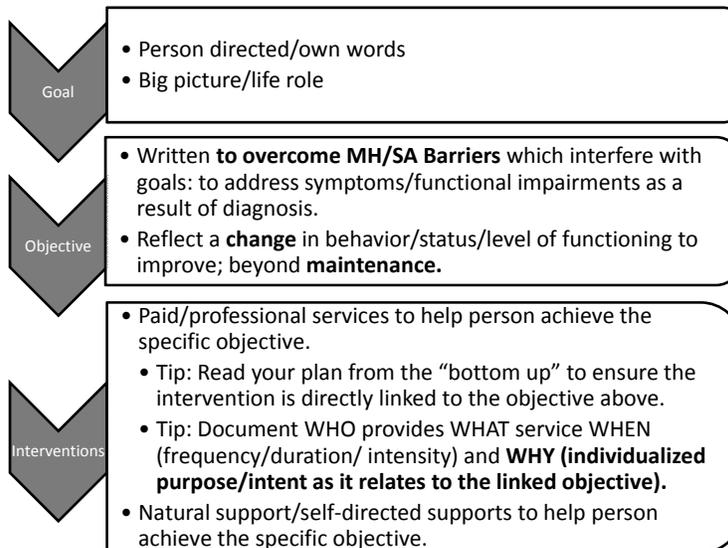


33

**Weave the *golden thread*  
of medical necessity  
throughout your documentation**



## Golden Thread of Medical Necessity



35

## Bridging the Two Worlds



36

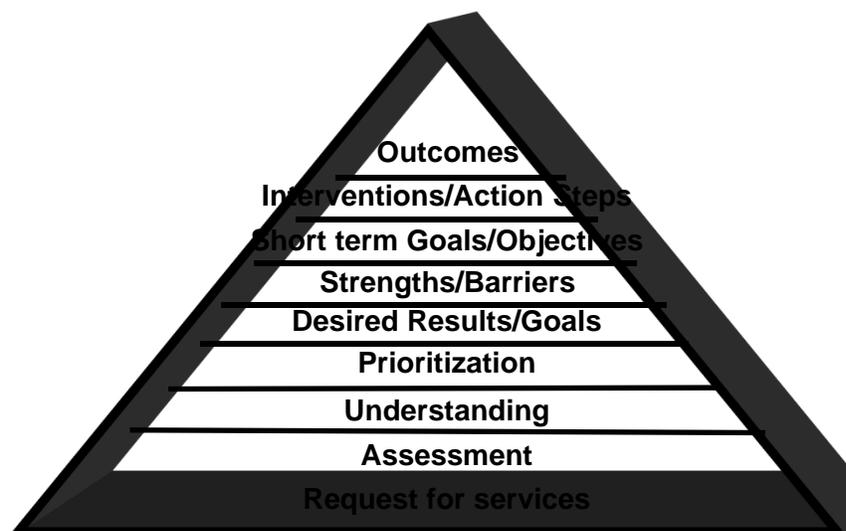
## Partnering with People so they can be in the Driver's Seat of their Treatment

- PCRP is based on a model of PARTNERSHIP...
- Respects the person's right to be in the driver's seat but also recognizes the value of professional co-pilot(s) and natural supporters



37

## Building the Plan



38

A plan is only as good as  
the *assessment*.

39

## Assessment

- Initiates helping relationships; ongoing process
- Focus on functional abilities and impairments as opposed to symptoms per se
- Comprehensive domain-based data gathering
  - Identifies strengths
  - Abilities and accomplishments
  - Interests and aspirations
  - Recovery resources and assets
  - Unique individual attributes
  - *Considers stage of change*

40

“The tasks of treatment differ as a function of the person’s stage of change....”



Substance Abuse Treatment and  
the Stages of Change  
by Connors, Donovan & DiClemente

41

## A Recovery Plan Should be Strength-based

The plan:

- explicitly asks for strengths and interests.
- focuses on the positive, supports the ability to have dreams.
- revolves around achieving goals rather than addressing deficits.



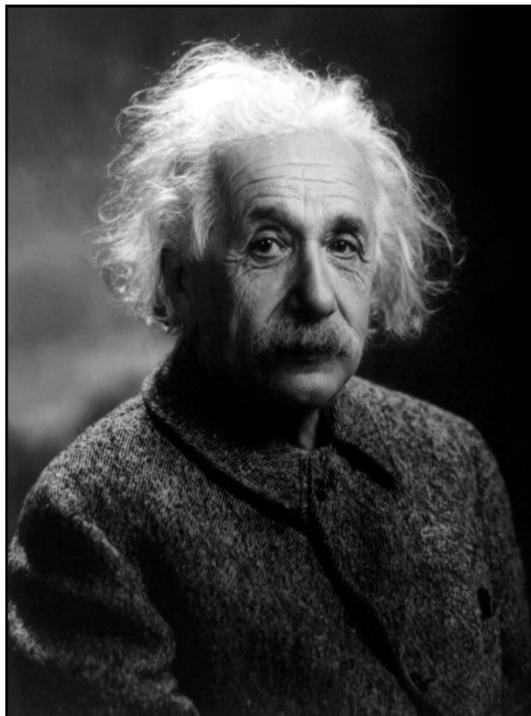
42



## Strengths

- Identified by the person, the provider, and also natural supporters/collaterals where appropriate:
  - environmental factors that will increase the likelihood of success
  - identifying the person's best qualities/motivation
  - strategies already utilized to help
  - competencies/accomplishments
  - interests and activities, i.e. sports, art
- Strengths shouldn't sit on a shelf! Use them constructively in the development of the plan.

43



O: Poor eye contact, unresponsive to social cues, preoccupation with parts of things.

A: R/O 299.80 Asperger's

P: Encourage client to explore part-time employment opportunities such as lawnmower repair or animal grooming.

## Examples of Strengths

- Motivated to change
- Has a support system –friends, family
- Employed/does volunteer work
- Has skills/competencies: vocational, relational, transportation savvy, activities of daily living
- Intelligent, artistic, musical, good at sports
- Has knowledge of his/her disease
- Sees value in taking medications
- Has a spiritual program/connected to church
- Good physical health
- Adaptive coping skills
- Capable of independent living



45

## Perspective

“It’s about what’s **STRONG**, not about what’s **WRONG!** ”

-Gina, a former patient at a state psychiatric hospital



46

## Remember the Power of Language

### Glass Half Empty

- Resistant/in denial
- Non-compliant
- “Frequent flier”
- Problems
- Manipulative
- Acting out
- “A Bipolar”

### Glass Half Full

- Pre-contemplative
- Prefers alternative approaches
- High user of services
- Needs/challenges
- Resourceful
- Person disagrees
- A person diagnosed with...

47

## Importance of Understanding

Data collected in assessment is by itself *not sufficient* for service planning.



48

## How Does the Assessment Information Come Together to Inform the Plan?

- Data collected in assessment is by itself *not sufficient*.
- Data must be woven together in a cohesive understanding of the whole person in Formulation or Integrated Summary.



- Informed by the person's view and your professional opinion.
- Is the “bridge” between the data and the plan; should have a direct link to the plan's content.

49

## Importance of Understanding

Formulation/understanding is essential:

- Requires skill, experience and judgment
- Moves from “what” (data) to “what does this mean **and how do we use it?**”
- Sets the stage for prioritizing needs and goals
- The role of culture and ethnicity is critical to true appreciation of the person served
- Assess stage of change
- Hypothesis

50

## A Chance to Put the Pieces Together

- Given the incidence of co-occurring disabilities and/or disorders, effectively addressing co-occurring disorders is critical to successful recovery:
  - Medical concerns
  - Substance use
  - Developmental disabilities
- When the assessment identifies co-occurring needs, they are considered in the formulation.



51

## Being “Transparent”

- Sharing the findings from the summary and/or sharing progress notes with the consumer is receiving much publicity now in healthcare, e.g. the Robert Wood Johnson “Open Notes study”, demonstrating increased patient satisfaction, understand care plan better, and increased medication conformance.
- Collaborative documentation with the consumer is the essence of being person-centered and promotes engagement.

52

Recovery-Oriented Care

Person-centered Shared Decision-making



Treatment Plans  
and  
Shared Understanding

53

## Goals

- Long term, global, and broadly stated
- Life changes as a result of services
- Ideally expressed in person's words
- Written in positive terms
- Consistent with desire for self-determination
  - may be influenced by culture and tradition



54

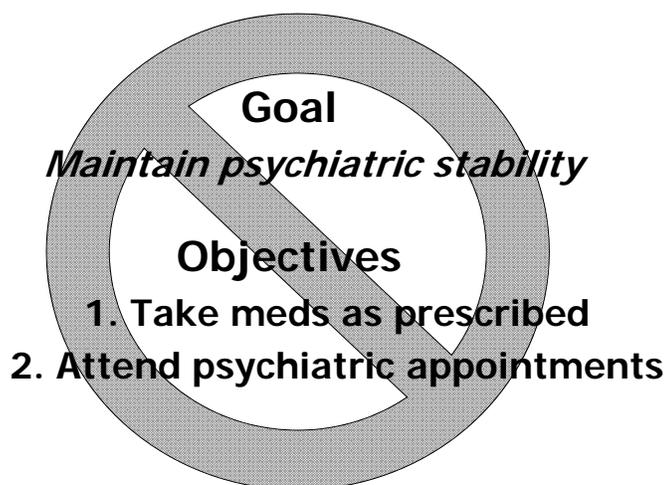
## What Do People Want?

- Manage their own Lives
- Social Opportunity
- Accomplishment
- Transportation
- Spiritual Fulfillment
- Satisfying Relationships
- Quality of Life
- Education
- Work
- Housing
- Health/Well-being
- Valued Roles

***To be part of the life of the community...***

55

And not just...



56

## Collaboration and Goals

An essential part of engagement  
Reaching agreement on the goal is essential

- The provider understands and appreciates the importance of the goal.
- The goal has immediate meaning and relevance for the consumer.
- The goal becomes a shared vision of success.
- Knowing consumers goals increases medication conformance, per APA Psychiatric News Alert (10/9/12).

57

## Some of What We See...

Remain at B&C for next 6 months  
Reduce angry outbursts  
Shower at least 1x/week  
Take medications as prescribed  
Refrain from alcohol consumption  
Reduce ER visits

I'm here to return your goals.  
You left them on my recovery plan.



**POWER OVER**

58

## Barriers = Challenges

- What is getting in the way of the person achieving their goal?
  - Why can't they do it tomorrow?
  - Why can't they do it themselves?
- Our job is helping the individual to identify and then remove/reduce/resolve/overcome barriers that occur as a result of the mental health challenges
  - symptoms
  - functional impairments
  - distress



59

## Objectives

- Expected near-term changes to meet long-term goals; big chunk/little chunk
- Essential features
  - behavioral
  - achievable
  - measurable
  - time framed
  - understandable for the person served



***Services are not an objective!!***

660

## Objectives should be SMART

- Here's a way to evaluate your objectives. Are they SMART?
  - **S**imple or Straightforward
  - **M**easurable
  - **A**ttainable
  - **R**ealistic
  - **T**ime-framed

61

## Interventions: Action Steps

- **Actions** by staff, family, peers, other natural supports
- Specific to an objective
- Respect recovery choice and preference
- Specific to the stage of change/recovery
- Availability and accessibility of services may be impacted by cultural factors
- Describes medical necessity



62

## Five Critical Elements

- Interventions must specify
  - provider and clinical discipline
  - staff member's name
  - **modality**
  - frequency/intensity/duration
  - **purpose/intent/impact**
- Clarifies who does what
- Including non-professionals



63

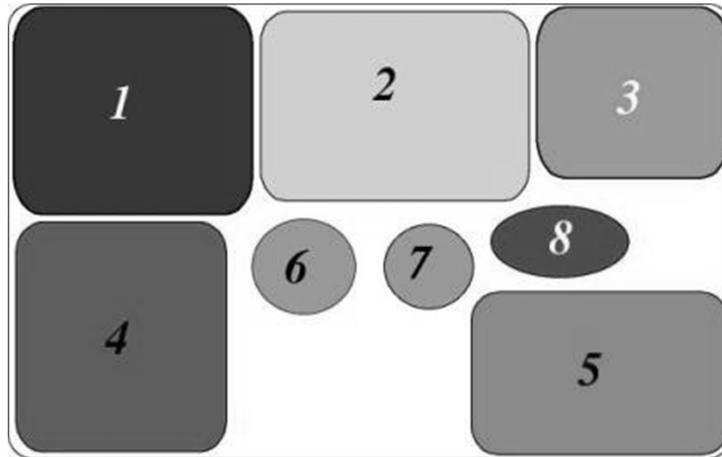
## Critical Elements

Wherever possible, include a task for the individual as well as family or other community or natural supporters.

- *Indicate the specific actions the person served will take to support achievement of the objective*
- *Indicate the actions/support the parent/guardian/community/ others will provide*

6.64

## Putting Together the Pieces



65

## An Example to Consider...

- Greg reports he is very lonely and that he just wants a girlfriend. He used to go to the downtown jazz fests and meet lots of people, but now he feels like a “zombie.”
- He is not getting out of the group home to do much of anything other than come to the Center. He wonders if this is due to his meds.
- Greg admits to being “terrified” to get out in the community and meet women, and states that its been 10 years since he had a girlfriend. He wouldn’t know where to start.
- He is currently unable to take the bus and is afraid to go anywhere alone.

66

## Greg's Plan

Goal: I want a girlfriend



### Strengths

- motivated to reduce social isolation
- supportive brother
- has interests and activities that he enjoys in the community (e.g., music, Chinese restaurants, bicycling)
- well-liked by peers
- humorous

67

## Greg's Plan

### Barriers/Assessed-Needs/Problems

- intrusive thoughts/paranoia increase social situations
- possible negative symptoms of schizophrenia and/or med side effects result in severe fatigue/inability to initiate
- easily confused/disorganized
- need for skill development to:
  - use public transportation/increase community mobility
  - develop symptom management/coping strategies
  - improve communication and social skill
  - attend to personal appearance



68

## Greg's Plan

### Objective:

-Greg will effectively use learned coping skills to manage his intrusive thoughts to participate in a minimum of 1 preferred social activity per week for the next 90 days.



69

## Greg's Plan

### Interventions

- ❖ Jane Roe, Clinical Coordinator, to provide CBT 2X/mos. for next 3 mos. to increase Greg's ability to cope with distressing symptoms in social situations.
- ❖ Dr. X to provide Med management, 1X/month for next 3 months to evaluate therapeutic impact and possible side effects to reduce fatigue and optimize functioning.
- ❖ Greg will complete a daily medication side-effect log for the next 2 months while meds are evaluated and adjusted.
- ❖ Greg's brother, Sam, will go for a bike ride with him 1x p/w to help Greg reduce stress/anxiety.

70



And, finally...

**"If you don't know where you are going, you will probably end up somewhere else."**

-Lawrence J. Peter

71

Tracy Abzug, LCSW      [tracy.abzug@dshs.state.tx.us](mailto:tracy.abzug@dshs.state.tx.us)

**PCRP IN PRACTICE:  
AUSTIN STATE HOSPITAL (ASH)**

72

## Where to from Here?

- From PCRP *knowledge* to PCRP *implementation*
- Lessons learned from the field - ASH



73

## ASH

- Peer Support Program
- Reduction in use of Seclusion/Restraint
- Creation of the Recovery Program Manager position

74

## Background

2004 - Hogg Foundation training on seclusion and restraint reduction

2007 - ASH was one of four state hospitals in Texas selected to participate in the STARS grant (State of Texas Alternatives to Restraint and Seclusion)

Byproducts of the STARS Grant include:

- Peer Support
- Comfort room supplies added
- Sensory integration
- Environmental enhancement strategies i.e.. Project Hope

2008 - Healing Today, Hope for Tomorrow training was developed

2012 - ASH was selected to be the hospital site for Via Hope's PCRCP pilot (SS EF)

2013 - PCRCP pilot with Via Hope's support on SS CD and APS

- Integration of sustainability tools; i.e., in-house support, coaching, training

September 2013 - Starting PCRCP pilot with Via Hope's support on CAPS and APS B

- More focus/training on enhancing internal sustainability

75

## Welcome Packet



76

# Communication



77

# Visual Safety Plan



78

## Re-telling the Person's Story



79

## Staff Training

- PTSD
- Coping Skills



80

## Chewing Gum



81

## Support at all Levels



82

## Employee Recognition Program “Caught in the IACT”

Informing ASH's Culture and Treatment:

- *Supporting* person centered care in recovery
- *Partnering* – with persons served, Recovery Teams, all staff, families, students, the community – EVERYONE
- *Offering* choices/options
- Demonstrating *flexibility & creativity* in providing services
- Identifying and *integrating individual strengths* – persons served and all staff
- Encouraging the *involvement of persons served in their own recovery*
- Communicating *HOPE*
- Advocating / assisting *on behalf* of patients
- *Actively spending time with patients* – more than just watching & directing
- Using *person first* language

83

## Challenges

- Change in processes, procedures, way of thinking
- Large organization  
Training all staff – direct care and ancillary resources
- Software incompatibilities
- Keeping the plan alive after the hospitalization (outpatient)

84

## Person-Centered Planning Success Stories



85

### Epilogue to *Treatment Planning for Person-Centered Care*

- Dr. Laurel Blackman, Austin State Hospital has written the epilogue for the 2nd edition book.
- She says...
 

“PCRP is not an idea or outcome on a piece of paper. It is not something patients do when they are better or keep handy for later reference after they discharge from the hospital. It is not something staff might do or try when they have the time or external motivation to do so. It is not some new age philosophy or academic think tank consensus for better delivery of mental health care and services...”

86

## Dr. Blackman cont.

- PCRP is “action and activity and connection and consideration at every possible exchange or juncture occurring at any time of day on any day of the week. It is what we try, do, or help make happen with individuals who come to us either by circumstance or choice. It is a far and wide reaching priority for the preferences and things of importance to those with whom we partner, whatever that might be whenever and however voiced, as we go about our workdays to offer the best care we can to the great variety of people who are our patients. Each detail and interaction, large or small, counts.”

87

## Questions and Answers



Mike Maples, Assistant  
Commissioner, Assistant  
Commissioner of Mental  
Health and Substance  
Abuse, DSHS

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For those in the auditorium, please come to the microphone to ask your question.

88

## Next Grand Rounds

**Nov. 6**

**Healthy Texas Babies:  
Antenatal  
Glucocorticoid  
Therapy, Past,  
Present,  
and Future**



Presenter:  
Donald Dudley, MD, UT Health Science Center at San Antonio