NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

How to Design and Use Electronic Health Records to Optimize Person-Centered Planning

yale program for recovery and community health

Janis Tondora, PsyD and Daniel Wartenberg, PsyD, MPH

December 12, 2024

Housekeeping

We will **mute audio for ALL** to reduce interference. You can unmute as needed.

For **technical issues** with audio, video, Zoom, **please direct questions in chat to Ingrid Padgett.**

Access your chat box to post questions. We want to hear from you.

Janis Tondora, PsyD (she/her) is an Associate Professor in the Department of Psychiatry at the Yale Program for Recovery and Community Health. Her work involves supporting the implementation of person-centered practices that help people with behavioral health concerns and other disabilities to get more control over decisions about their services so they can live a good life as they define it. Dr. Tondora has done this work in partnership with over 25 states, and multiple international collaborators, where she both teaches and learns from, stakeholders committed to person-centered systems transformation.

Meet Janis

Fun Fact:

Outside of work, you may find Janis enjoying the great outdoors with her family (human and furry!) on a paddleboard, in the mountains, or at the beach.

How about you? What hat(s) are you wearing today?

Audience Participant Poll (Multiple Hats Allowed)

- Direct support practitioner
- Peer support specialist
- Supervisor/Team Leader
- Family Member/Natural Support
- Guardian/Conservator
- Leadership/Administration
- Managed Care/Funder
- *Service recipient/Person with Lived Experience
- Advocate
- IT/Technical Specialist
- Other: Add to the chat-box

*A note on our use of terms: *Service user/participant, client, person in recovery, patient, person with a disability, psychiatric survivor, person with lived experience, person in distress, consumer.* ***Always honor individual preferences and when in doubt, ASK!***

History of PCP in NC Timeline

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Roots in person-centered approaches to support Thomas S. class members in 1990s

Original NC PCP Manual in 2010

Evolution of "recovery-oriented care" in the behavioral health space

2020 "desk reviews" indicated a need for continued system-wide focus on PCP

Multi-year, multi-stakeholder PCP Workgroup

Creation of the *NC Person-Centered Planning Guidance Document (effective 11-02-2023)*

Widespread introductory training (2022-23)

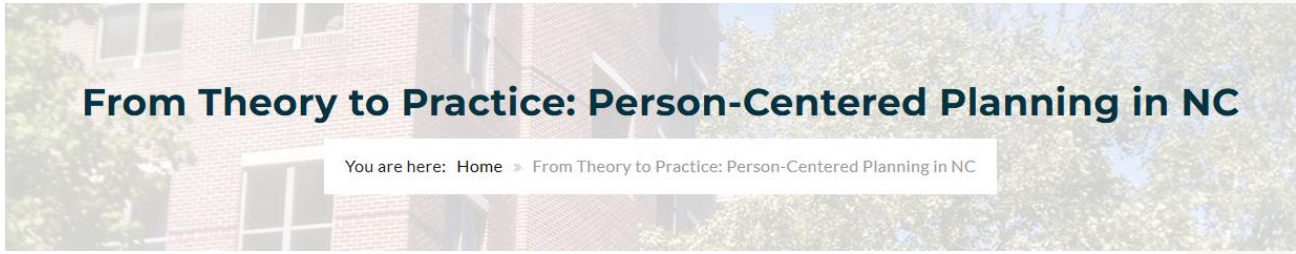
Required of all providers working in programs where PCP is included within the service definition

DMHDDSUS recognizes the ongoing need for resources/tools to support PCP

Webinars on PCP "hot topics," an NC PCP Resource Toolkit website, and more!

This introductory training remains available on the UNC Behavioral Health Springboard platform.

The North Carolina PCP Resource Toolkit website builds upon an online three-hour training which introduces the key principles and practices of PCP.



The training is housed on the UNC Behavioral Health Springboard website at https://bhs.unc.edu/theory-practice-person-centered-planning-nc for anyone to take free of charge any time.

…“right to live, love, work, learn, play, and pursue their dreams in the community" (North Carolina Person-Centered Planning Guidance Document, 2024).

Is a person-centered approach at the level of service delivery enough?

When you pit a good person against a bad system, the system always wins…

It is a BOTH/AND not EITHER/OR approach to person-centered transformation

Multi-level PCP Implementation: What does it look like?

- **EVERYONE has an important contribution to make to person-centered care: clinicians AND… administrative staff, security, plant operations, Board of Directors, IT, marketing, QM, leaders (local and state-level!), Tailored Plans**
  - Articulating mission/vision
  - Engaging funders to promote consistency in expectations
  - Reflecting on policies and procedures
  - Building and disseminating PCP tools and resources, including FAQ documents; assessment and planning templates, **electronic health record designs**
  - Establishing QI mechanisms to continuously get feedback from both individuals served and those who serve them
    - Responding to lived experience input in a meaningful way
  - Identifying and responding to PCP barriers

A Call to Action

SAMHSA issue brief provides information for State Mental Health Authorities about comprehensive strategies for promoting person-centered planning.

Emphasizes the importance of system-level alignment in recognition of the fact that:

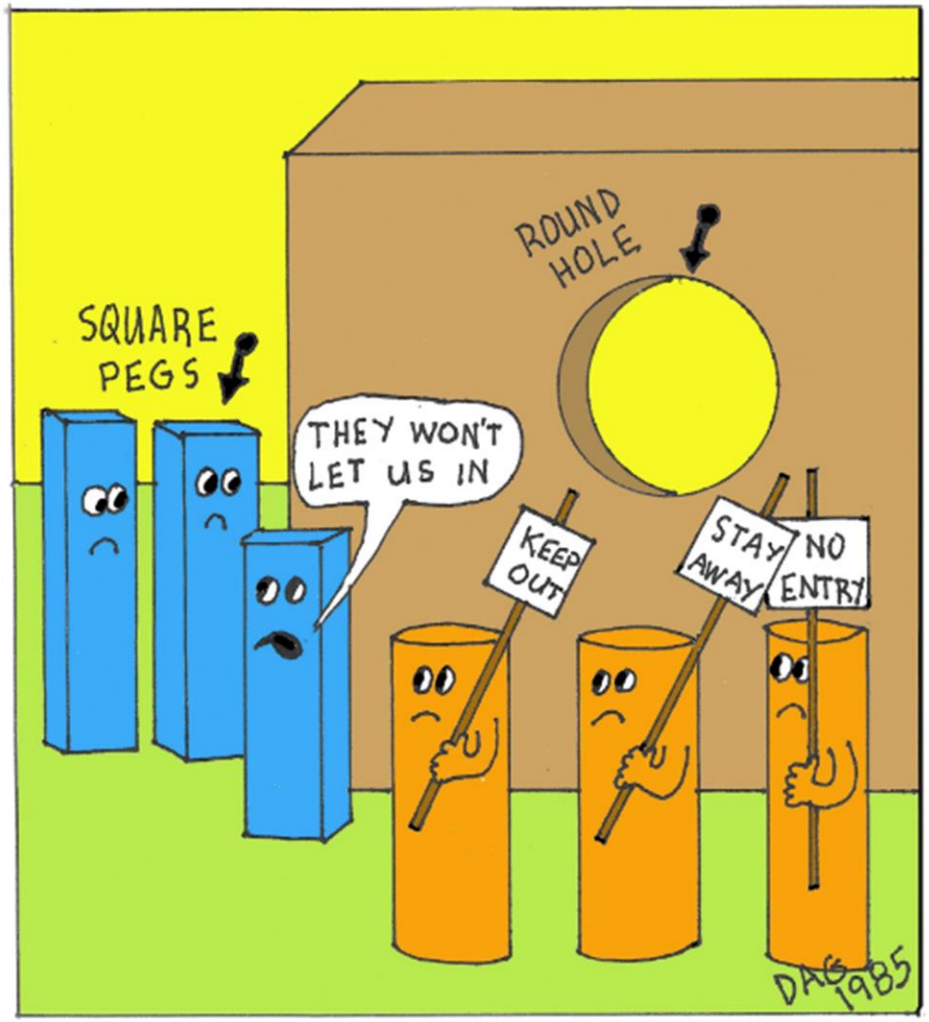
- *Even the most competent and committed PCP practitioners will not be able to fully actualize their competency in practice in the absence of systems characteristics that align in support of person-centered planning.*

SAMHSA Issue Brief: Person-Centered Planning, 2024

Training and workforce development only gets you so far…

- *But what about the talented and committed practitioner – one who believes in a person's right to a person-centered plan, one who is committed to partnering with them to create it, and one who has the skill to document its content, but they are forced to do so using a treatment planning template or electronic health record that is dominated by problems, pathology, and a complex workflow designed more to support payment than the person and their recovery and life goals?*

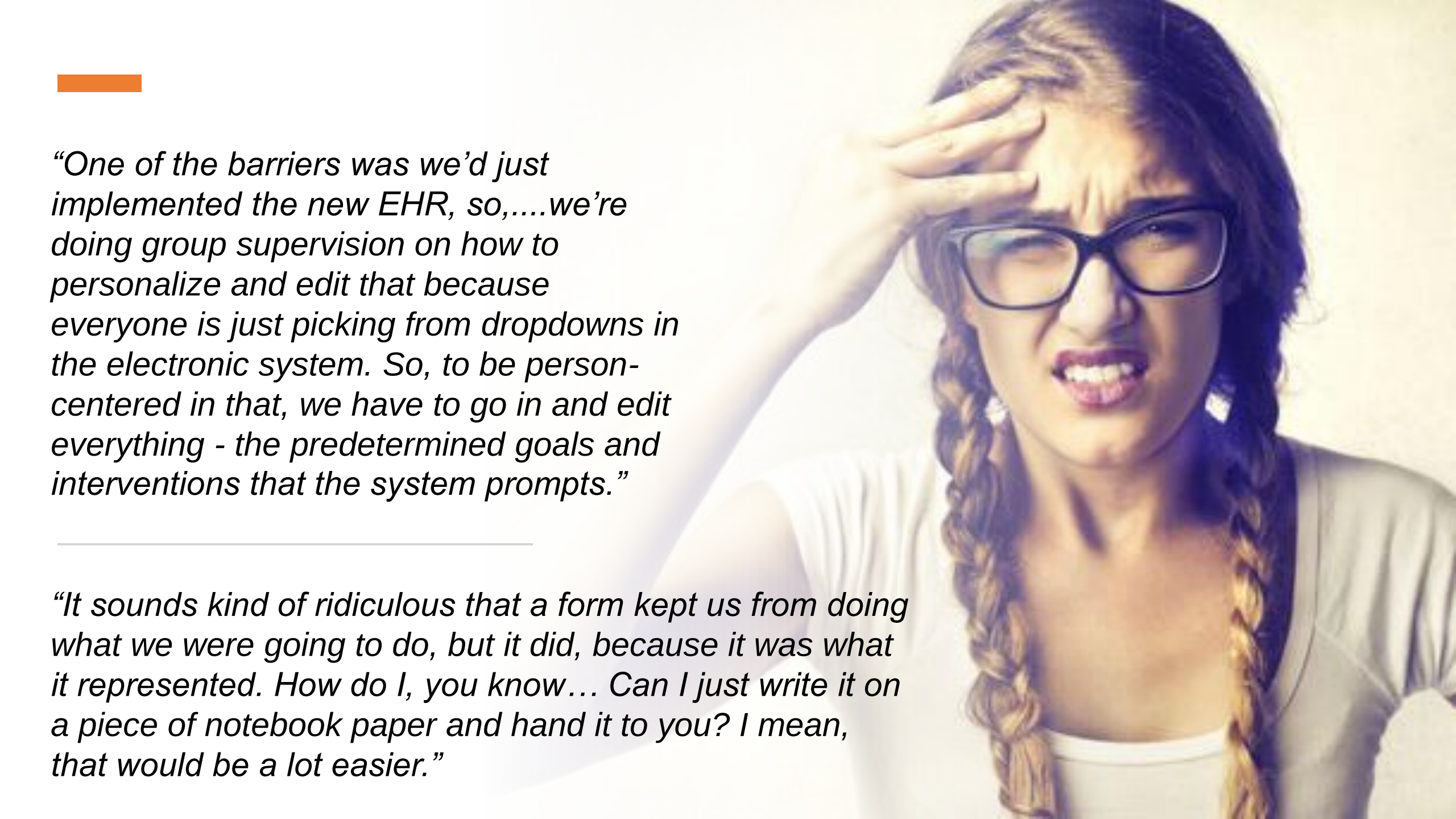
A Fundamental Disconnect



- *The so called "square peg in a round hole" dilemma leads even the most person-centered of practitioners to develop plans that often have little meaning to the individual and limited impact in guiding the recovery process over time.*
  - The Promise and Pitfalls of Electronic Health Records and Person-Centered Care Planning
    - Tondora, Stanhope, Grieder, & Wartenberg, 2021.

“One of the barriers was we’d just implemented the new EHR, so,....we’re doing group supervision on how to personalize and edit that because everyone is just picking from dropdowns in the electronic system. So, to be person-centered in that, we have to go in and edit everything - the predetermined goals and interventions that the system prompts.”

“It sounds kind of ridiculous that a form kept us from doing what we were going to do, but it did, because it was what it represented. How do I, you know… Can I just write it on a piece of notebook paper and hand it to you? I mean, that would be a lot easier.”



Daniel Wartenberg, PsyD, MPH, has been instrumental in developing and implementing person-centered, evidence-based behavioral health programs for more than 35 years. As the CEO of the Southwest Connecticut Mental Health System, he led the organization's transformation to a person-centered, recovery-oriented system of care. In collaboration with national experts from Yale University, he has designed and fully implemented an entirely recovery-driven electronic health record. Dan has successfully operationalized a number of evidence-based practices including, Integrated Dual Disorder Treatment and the Zero Suicide approach to suicide prevention.

Meet Dan

Fun Fact:
Outside of work you can find Dan playing saxophone with his aging rock star cover band.

Would you say that your EHR or planning template…

Audience Participant Poll

- makes it easier to write person-centered plans?
- has no impact on making plans person-centered?
- hinders the ability to write person-centered plans?

One Agency's Journey: Lessons Learned in EHR Design & Implementation

"We just need to stop accepting what is and start creating what should be…"

- Dale DiLeo

Newport Mental Health

Considerations in EHR Plan Design

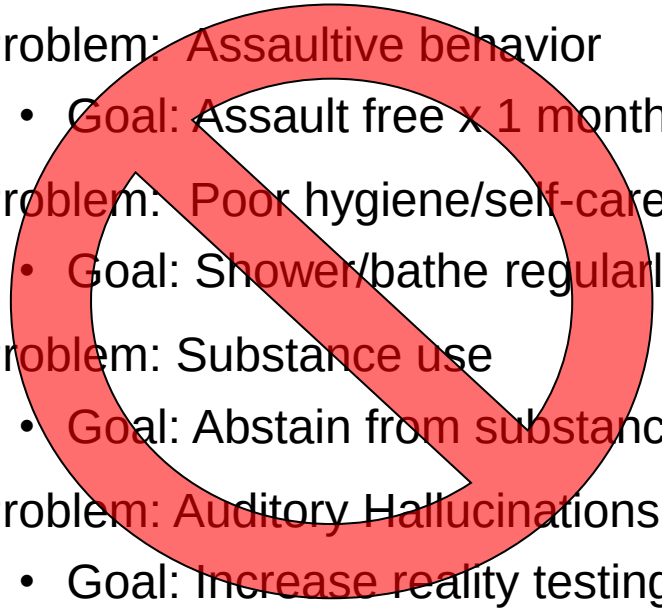
The structure/flow of elements reflects person-centered principles.

- Goals are NOT derived from the “problem list” or list of “assessed needs”
  - This is perhaps the SINGLE most important design consideration; The person-centered goal/recovery vision is the starting point!
  - “problems” are addressed later as barriers to reaching the person’s goal.
- The plan is created through a dialogue where both the person and practitioner have the opportunity to weigh in.
  - Dedicated space for BOTH voices (when needed – plan content does not ALWAYS need an additional professional explanation- this is especially true ot the person-centered GOAL statement)
  - Place to document “agreeing to disagree.”
- Plan structure integrates the use of strengths to overcome barriers
- Sequencing: The ordering of info/sections matters; hopes/dreams/strengths…up front rather than leading with diagnosis

This is a significant shift in the logic/flow of treatment plan documentation…

Problem-Centered
One Goal for Every Problem as Identified in the Assessment

- Problem: Assaultive behavior
  - Goal: Assault free x 1 month
- Problem: Poor hygiene/self-care
  - Goal: Shower/bathe regularly
- Problem: Substance use
  - Goal: Abstain from substances
- Problem: Auditory Hallucinations
  - Goal: Increase reality testing



Person and Goal-Centered
Goal of the PERSON and How Barriers Interfere

I want my job back so I can provide for my kids.

- Physical conflicts … ker led to termination. *I … y let me go.*
- Difficulty w… *my best at interviews*
- Substanc… d job loss *I called out …*
- Distress from … ult to focus at work *I make a lot … when my symptoms are really bothering me.*

Newport County Community Mental Health Center

Treatment Plan

01 - Psychiatric / Target Symptoms / Medication Monitoring

Problem: Problem(s) related to Psychiatric Symptoms, Medication Monitoring
Active: 04/24/2018 - 04/24/2019
Outcome:
Ray has a diagnosis of schizophrenia with sxs that can include paranoia, inappropriate behavior, poor hygiene and lack of interpersonal skills.

Long Term Goal: Long Term Goal(s) related to Psychiatric Symptoms and Medication Monitoring
Active: 04/24/2018 - 04/24/2019
Client to not experience an increase in negative sxs. Client to achieve psychiatric stability.

Short Term Goal: Short Term Goal(s) related to Psychiatric Symptoms, Medication Monitoring
Active: 04/24/2018 - 04/24/2019
Client to reduce oral medications without a negative change in sxs.
Intervention: Intervention(s) related to Psychiatric Symptoms, Medication Monitoring
Start Date: 04/24/2018 Frequency: 3x a week Person Responsible: j. M
Client to meet with prescriber and discuss reduction of oral meds.
Client to remain current level of supervised meds picking up 3x a week
Case manager to meet with client and educate on negative sxs of his diagnosis
Case manager to prompt as necessary to mange negative sxs of diagnosis.

Signatures	
Acknowleged by:	**On**
JM - Subst. Abuse Spec. HS, LCDP	Apr 24 2018 9:36AM

Problem: Problem(s) related to Psychiatric Symptoms, Medication Monitoring
Active: 04/24/2019 - 04/24/2020
Outcome:
R is diagnosed with Schizophrenia with symptoms that include paranoia ,inappropriate behavior, poor hygiene and lack of interpersonal skills.

Long Term Goal: Long Term Goal(s) related to Psychiatric Symptoms and Medication Monitoring
Active: 04/24/2019 - 04/24/2020
LT Goal Annual 4/24/2019: R will work on decreasing negative symptoms as they relate to his diagnosis and report symptoms to his Team as they present. He will maintain psychiatric stability.

Short Term Goal: Short Term Goal(s) related to Psychiatric Symptoms, Medication Monitoring
Active: 04/24/2019 - 04/24/2020
ST Goal 4/24/2019: R will keep scheduled appointments with staff and Prescriber/Provider at 65 Valley Road. He will work on increasing his ability to hold medication from 3 days per week to 2 days per week on the supervised medication monitoring program within the next 6 months.
It should be noted that R is unwilling to come off of oral medication. He is scheduled to present to 65 Valley Road three days per week for his supervised medication.
Intervention: Intervention(s) related to Psychiatric Symptoms, Medication Monitoring Start Date: 04/24/2019 Frequency: weekly Person Responsible: PCM/R
Ray will meet with his PCM and staff, as well as keeping appointments with prescriber and presenting for supervised medication as scheduled. R and PCM will continue to work on identifying symptoms. PCM and staff will educate Ray on strategies that will assist him in understanding his negative symptoms related to his diagnosis.

Long Term Goal: Long Term Goal(s) related to Self Care / Developmental Issues
Active: 04/24/2018 - 04/24/2019
Client to maintain his personal hygiene and laundry and apartment without prompting or assistance.

Short Term Goal: Short Term Goal(s) related to Self Care / Developmental Issues
Active: 04/24/2018 - 04/24/2019
Client to shower at least 4x a week with prompting
Client to complete laundry weekly on his own.
Client to maintain upkeep of his apartment with his mother's assistance.
Intervention: Intervention(s) related to Self Care / Developmental Issues
Start Date: 04/24/2018 Frequency: weekly Person Responsible: J. M
Client's mother to support client weekly with upkeep of apartment and prompting for laundry.
PCM to assess client hygiene at each visit.

Signatures	
Acknowleged by:	**On**
JM- Subst. Abuse Spec. HS, LCDP	Apr 25 2018 10:40AM

Problem: Problem(s) related to Self Care / Developmental Issues
Active: 04/24/2019 - 04/24/2020
Outcome:
Ray presents with poor self care and daily living skills. He lacks the motivation to keep up with his hygiene, as well as his living space. His ADL's require assistance. His hygiene is not always maintained.

Long Term Goal: Long Term Goal(s) related to Self Care / Developmental Issues
Active: 04/24/2019 - 04/24/2020
LT Goal 4/24/2019: Ray will maintain his personal hygiene . He will work on getting his laundry washed and dried and keep his apartment clean and up

Short Term Goal: Short Term Goal(s) related to Self Care / Developmental Issues
Active: 04/24/2019 - 04/24/2020
ST Goal 4/24/2019: R will shower at least 4x per week with assistance to be reminded by PCM and staff when he presents to 65 Valley Road. He will complete getting his laundry washed and dried on his own and receive monies from his budget to complete this task. He will receive prompting to manage his ADL skills and his mother will also assist him in achieving this goal. Within the next six months, R will have monthly checks on his apartment by staff and decrease his prompting to keep his hygiene maintained.
Intervention: Intervention(s) related to Self Care / Developmental Issues Start Date: 04/24/2019 Frequency: weekly Person Responsible: PCM/R
Intervention 4/24/2019: R will work with his PCM, Team members and other staff to identify his current level of need to maintain his personal hygiene. He will meet with PCM/Staff to develop a cleaning schedule to maintain his living space. His PCM or other staff on his Team will visit R and assess his living space and determine if more assistance and prompting is needed to achieve this goal.

Signatures	
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HO- Program Coordinator MS	May 19 2019 2:08PM

08 - Legal / Finanical

Problem: Problem(s) related to Legal / Financial Issues
Active: 04/24/2018 - 04/24/2019
Outcome:
R has difficulty with managing and budgeting finances

Long Term Goal: Long Term Goal(s) related to Legal / Financial Issues
Active: 04/24/2018 - 04/24/2019
Client to manage his funds from social security without need for repayee services.

New and Improved PCP Format ☺

Newport Mental Health

Recovery Plan

Person in Recovery:

Recovery Plan Start: Next Recovery Plan Due: Recovery Plan End:

Time Frame:

Integrated Summary:

Recovery Goal:

Additional Staff comment

Strengths and Resourc

Barriers

Personal/Clinical Ba

Systemic/Environme

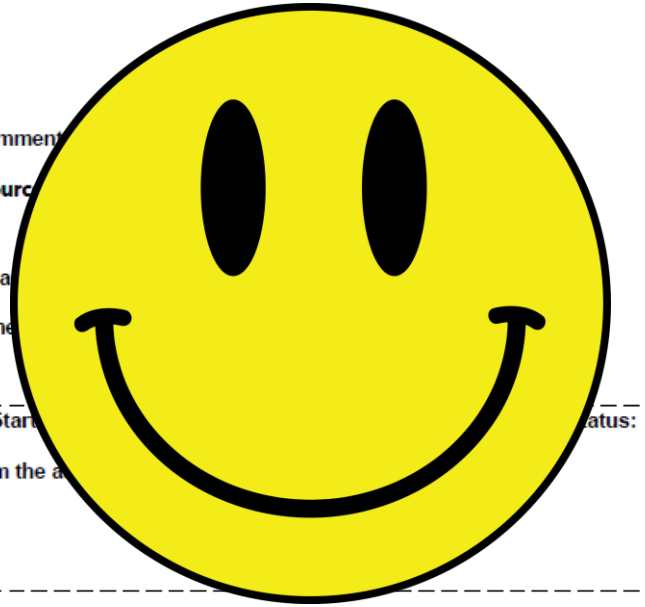
Objective(s):

Objecitve #: Start atus:

Which barriers from the a

As Evidenced By:

Progress:



Services to be provided by Agency:

Service Type	Provider Type	Frequency	Duration	Objectives Addressed	Service Description

Assistance to be provided by Community or Natural Supports and Other Providers:

Person	Type Of Support	Nature Of Support

Considerations in EHR Plan Design:

The structure balances technical efficiencies with individualization

- Easy to navigate user interface to promote efficiency and “compliance” where possible but WITHOUT sacrificing individualized content and defaulting to pre-determined planning templates:
  - Drop downs vs. open text:
    - Many aspects of the services/interventions statements lend themselves to drop-down selections promoting efficiency. This is especially true of the WHO/WHAT/WHEN aspects of intervention statements.
    - But free-text capacity is still needed to describe the individualized purpose/intent of the intervention, i.e., the WHY
- Hard-wired logic vs. flexibility
- Impact of auto-populating libraries with pre-set text

Auto-population in Plan Development: A Cautionary Note

- *EHR platforms designed around pre-set libraries that make inherent algorithmic assumptions (e.g. select a diagnosis that then auto-populates a preset problem list and a matching set of objectives and services) have NO place in person-centered planning.*

- *Such diagnostically-driven designs go against the most fundamental values of PCP and fail to recognize the unique nature of each person's journey*

Considerations in EHR Plan Design

The structure is not organized around required “domains”

- Avoid “Domain-based” planning structures which require users to rigidly classify, and then separate, goals into discrete “required” categories
- Plan structure should allow for integration of multiple need areas underneath an overarching person-centered goal, e.g., through the inclusion of diverse short-term objectives
- Optimal EHR design is never a substitute for critical clinical and patient-centered thinking!

Considerations in EHR Plan Design

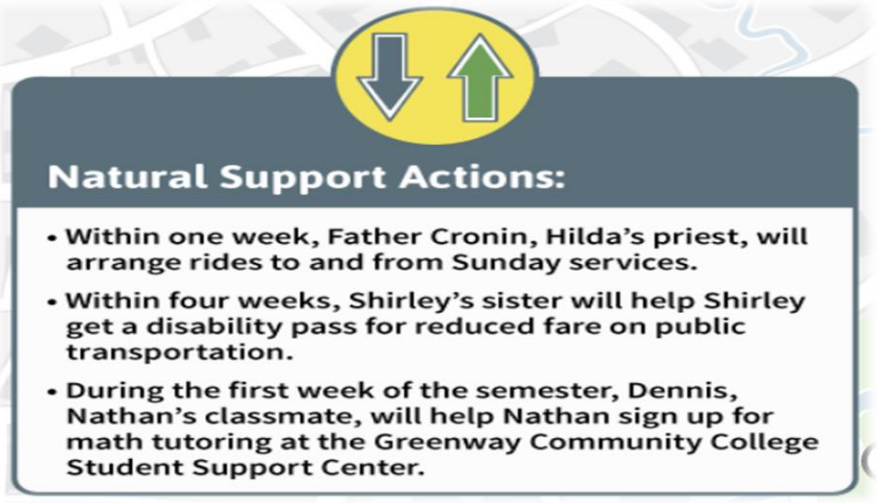
Plan prompts build self-agency and natural support networks

- Fields for documentation of natural supports' contributions at the person's discretion
- Self directed actions by the individual; indicate what the person will do (ideally building on strengths and interests) not just what will be done *to them/for them*
- Both of the above can be entered as their own unique fields or they can be integrated into the interventions/action section of the plan with the person or natural supported listed as the "responsible party"
- Staff views are clearly designated as such so that the professional perspective can be included without obscuring the person's perspective

Self Directed and Natural Support Actions

Self-directed actions are a reminder that the person, too, has a responsibility in contributing to the recovery plan.

- **Natural Support** actions reflect the growth of the informal recovery network that supports the person's recovery over time.



Sample Prompts/Format

Recovery Goal: A statement of the overall goal, in the participant's own words, expressing a desired change, improvement, or recovery outcome

Additional Staff comments (if needed): When necessary, use to clarify the person's goals or to reflect the staff perspective when there is significant disagreement

Strengths and Resources: Skills, qualities, or experiences that may help the person achieve their goals. Consider values, areas of interest, strengths, and personal, and community supports.

Personal/Clinical Barriers: Problems/needs/functional impairments/skill deficits from the assessment that interfere with goal attainment, with a particular focus on those needs directly related to mental health and/or addiction issues

Systemic/Environmental Barriers: Practical/systemic/and resource issues (e.g., no transportation to clinic, services not available in primary language, wait lists for preferred program, etc.).

Sample Prompts/Format

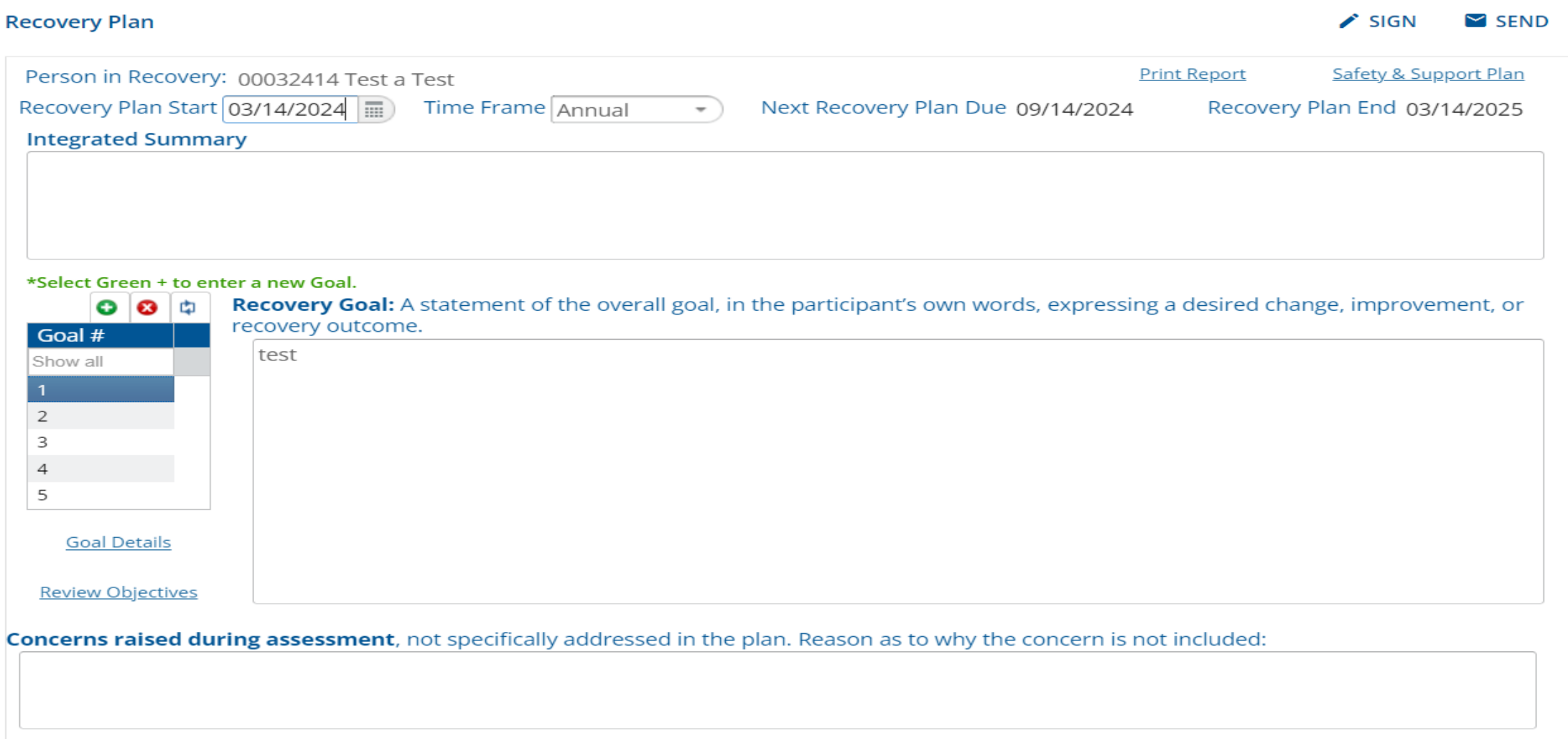
Assistance to be provided by Community or Natural Supports and Other Providers: Other people (external to your organization) who have important contributions to make to the individual's recovery plan. This should include professionals (e.g., a medical doctor, a probation officer, an employment specialist, school counselor, etc.) as well as natural supports (e.g. family member, friend, employer).

Person Providing Support/Services	Nature of support

Concerns raised during assessment, not specifically addressed in the plan. Reason(s) as to why the concern is not included:

Personal Wellness Strategies: Things done on a regular basis to manage stress and optimize wellbeing, ideally linked to personal strengths/interests

NMH Sample – Goals First



NMH Sample – Wellness Strategies, Discharge Criteria, Diagnosis

Personal Wellness Strategies: Things done on a regular basis to manage stress and optimize wellbeing, ideally linked to personal strengths/interests:

Personal Recovery Attainment for Transfer/Discharge Planning: How is it known that change in level of care is evident? (check all that apply)

- ☐ Individual has experienced stability within and/or overcome their identified personal/clinical barriers
- ☐ Individual has increased their level of functioning through use of identified strengths and personal wellness strategies in obtainment of their targeted objectives
- ☐ Individual has met their identified targeted objectives in achievement of their recovery goal(s)
- ☐ Individual and clinician have identified a need for transfer of care due to a decreased/increased need for additional resources and supports

Diagnoses: G24.01 - Drug induced subacute dyskinesia

Reason(s) why client was unable/declined to sign and/or unavailable to participate in the development of this recovery plan:

End Recovery Plan

NMH Sample Strengths, Barriers

Recovery Plan Goals

Goal # 1

Recovery Goal: A statement of the overall goal, in the participant's own words, expressing a desired change, improvement, or recovery outcome.

test

Additional Staff comments (if needed): When necessary, use to clarify the person's goal or to reflect the staff perspective when there is significant disagreement.

test

Strengths and Resources: Skills, qualities, or experiences that may help the person achieve their goals. Consider values, areas of interest, strengths and personal and community supports.

test

Barriers:

Personal/Clinical Barriers: Problems/needs/functional impairments/skill deficits from the assessment that interfere with goal attainment, with a particular focus on those needs directly related to mental health and/or addictions issues.

test

NMH Sample – Objectives, Services

Recovery Plan Goals

Systemic/Environmental Barriers: Practical/systemic/and resource issues (e.g., no transportation to clinic, services not available in primary language, wait lists for preferred program, etc.).

test

Objectives: Concrete steps that will be proof that the person is overcoming a mental health/addictions barrier and making progress toward their goal.

* Select Green + to enter a new Objective.

Objective #	Start Date	Target Date
Show all	Show all	Show all

Which barriers from the assessment are you addressing in this objective?

As evidenced by: (e.g. concrete accomplishment or change in functioning)

Services to be provided by Agency: The range of clinical and rehabilitative services offered by **your agency** that will help the person to overcome their mental health/addiction barriers and achieve their objectives.

Service Type	Provider Type	Frequency	Duration	Objectives Addressed
Show all	Show all	Show all	Show all	Show all
Case Management	Case Manager	Weekly	1 year	1

Service Description

test

NMH Sample – Natural Supports

Assistance to be provided by Community or Natural Supports and Other Providers: Other people (external to your organization) who have important contributions to make to the individual's recovery plan. This should include professionals (e.g., a medical doctor, a probation officer, an employment specialist, school counselor, etc.) as well as natural supports (e.g. family member, friend, employer).

Person	Type Of Support
Show all	Show all
mom	
test	

Nature Of Support

Considerations in EHR Plan Design

The plan is integrated with other aspects of the record and clinical workflows

- How do other documents in your EHR reflect the principles of PCP?
  - How are assessments worded?
  - Pulling goals or objectives into progress notes
- Opportunities to promote patient activation and illness self-management
- Ability to pull-in or reference other documents or data (advanced directives, crisis management plans)
- Opportunities for direct client input through a portal system, measurement-based care, e.g., allows for the inclusion of WRAPs or Psychiatric Advance Directives
- Easily amendable to reflect changes over time, challenge of “living document” vs. point in time plan

Sample Assessment Questions

1. Relationships

Who are the most important people in your life right now? Are there people you can turn to when things get difficult? How are your friendships going? How are your family relationships going? Do you have (or hope to have) a romantic or sexual relationship-how is this going? Are there people that depend on you (children, elderly relatives)? Who are the people you turn to in times of difficulty?

_____

_____

What are your goals for forming or improving relationships?

_____

_____

What are the barriers to forming or improving relationships (e.g. I am shy, I haven't talked with my family for years, I don't know how to meet people)?

_____

_____

Staff comments:

_____

_____

Consumer Preference	Staff Suggestion	Decision
1. __ Work on Now 2. __ Work on Later 3. __ Not a focus	1. __ Work on Now 2. __ Work on Later 3. __ Not a focus	1. __ Work on Now 2. __ Work on Later 3. __ Not a focus

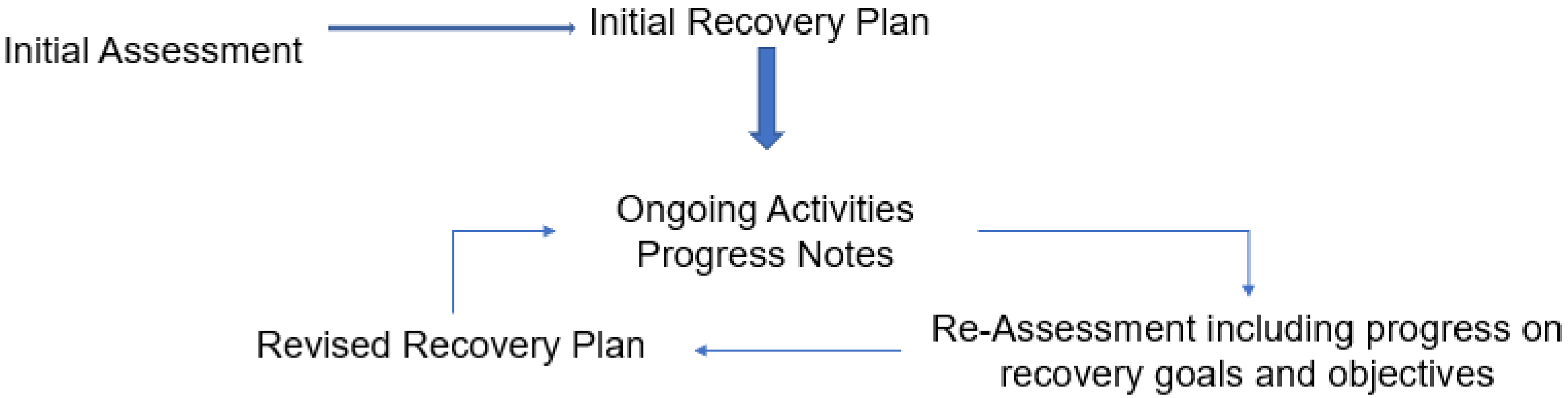
Building a Recovery Team

Important persons in life and recovery

Please help me make a list of all of the people that are important to you or can help you in recovery and think about how they could help you in your recovery. *(Include friends, family, employers, clergy and other persons and groups as well as clinicians and providers).*

Name	Relationship to you	How they could help with my recovery?	Contact OK?

Workflow and Plan Updating Over Time



Quality Use of the EHR Over Time: Lessons Learned

- Even the best EHR designs will not result in quality documentation in the absence of meaningful content and technical training, i.e., “traditional” content can still be forced into the most patient-centered of designs
- So, what are some strategies for reinforcing quality use of the EHR to build PCPs…

Clarity in Quality Expectations is Critical

- Mixed-messages” re: plan quality is a major implementation obstacle
- PCP Quality should be an “open-book” test
  - make the expectations clear and then provide tools and technical assistance to help staff meet them

Sample Tools and How to Use Them:

Help Text Guidelines

Plan Element	**Possible Help Text**
Integrated Summary or Understanding/ Changes to Understanding that Impact Current Plan	The Integrated Summary is a summary and analysis that blends the findings and opinions of all assessments with the preferences of the person served into a concise and clear synthesis. The Integrated summary is **not** a simple repetition of the data. A clinical hypothesis/understanding/core theme re: what drives the individual's experience of illness and recovery -the "why" question. The Integrated Summary establishes medical necessity for services and provides a clear rationale for why some, but not necessarily all, assessed needs are actively addressed in the recovery plan. Assessed needs are prioritized according to the person's valued recovery goal(s) and service preferences in general, but also may include needs that pose significant barriers to the person's safety or significantly impede the achievement of his/her personal or life goals (e.g. Employment, Housing, Relationships, Education). For Recovery Plan Reviews the Integrated Summary should focus on any changes/new info/new understanding that might impact what is included in the current plan (e.g. death of family member indicates new need for bereavement/grief work… a recently disclosed trauma history or substance abuse warrants the addition trauma informed or SA focus).
Recovery Goal	A statement of the overall goal, in the participant's own words, expressing a desired change, improvement, or recovery outcome. The goal statements on the plan/plan update are about having a meaningful life in the community, not only symptom reduction or compliance. Ideally, the goal reflects something "higher" – a valued community/life role that they want to obtain, and are in the individual's own words. The goal statements may not have a time frame. Ideally this would be reflected by an "I" statement in quotes. "I'd like to join a choir." "I want a better relationship with my dad." Resist the temptation to write too many goals. The intent of the Individual Service Plan is to make change a manageable process. Having too many goals in the plan complicates the efforts of individuals, families and providers. Too many goals is simply overwhelming for everyone and undermines the whole process. Keep goals simple and focused toward a positive result. Ask the participant to complete the sentence, "In my life, I want to… "
Additional Staff comments: Optional	When necessary, use to clarify the person's goal or to reflect the staff perspective when there is significant disagreement. Ideally staff comments are reflected in the statement of the Recovery Goal which while stated in the

Sample Tools and How to Use Them:

QI Measures & Processes

Person Centered Recovery Plan Quality Review Tool

Item #	Documentation Indicator & Review Tips	Fully Meets Criteria (Exemplar example – No recommendations for improvement)	Meets Most Criteria (Good demonstration of quality criteria but would benefit from some enhancements)	Limited Criteria Met (Limited demonstration of quality criteria; requires some significant improvement)	Does Not Meet Criteria/ Plan Element Absent (Does not reflect understanding of quality criteria; requires major revision)	Comments/ Observations* *Please add a qualitative comment for "exemplar" examples if something was particularly well-done AND for all "Most/Limited/Does Not Meet" ratings please describe what was lacking.
1	The **narrative/interpretive summary** includes brief references to the following required elements: 1. Strengths, interests, and current and/or desired life roles and priorities. 2. A brief reference to primary presenting problem/barriers. *This is critical to include in supporting your golden thread of medical necessity and explains the person's need for services. Note this can be a brief reference as you have the opportunity to elaborate later in the Recovery Plan in the Barriers fields. 3. Individual's stage of change/stage of recovery (Stage of readiness for any relevant behavior change that could help them move towards their goal) 4. Natural supports or community resources 5. Cultural factors and any impact on treatment 6. A core theme/understanding re: what drives the individual's experience of illness and recovery -the "why" question. Are there any unmet needs (e.g., trauma history) that have perpetuated the person's difficulties? May not always be known but is important to consider.					
2.	The plan/plan update is developed collaboratively and there is **evidence of direct input from the person**, e.g., the includes quotes from the individual and/or statements such as "Jose stated…" and there is evidence they were offered a copy of the plan (Note: This may be found in a progress note following the planning meeting or directly on the plan itself.)					

Front-end Considerations in EHR Vendor Selection

- Degree of customization – both initially and over time as needed for modifications
- Access for multiple users to allow for multi-disciplinary planning
- Structural link between the assessment and plan – what carries over and HOW (auto-population?)
- Hybrid use of drop-downs (to promote efficiency where appropriate, e.g., interventions) alongside opportunity for free text entry
- Interface between plan fields in EHR and service authorization and billing

Tips for Surviving the “Go Live”

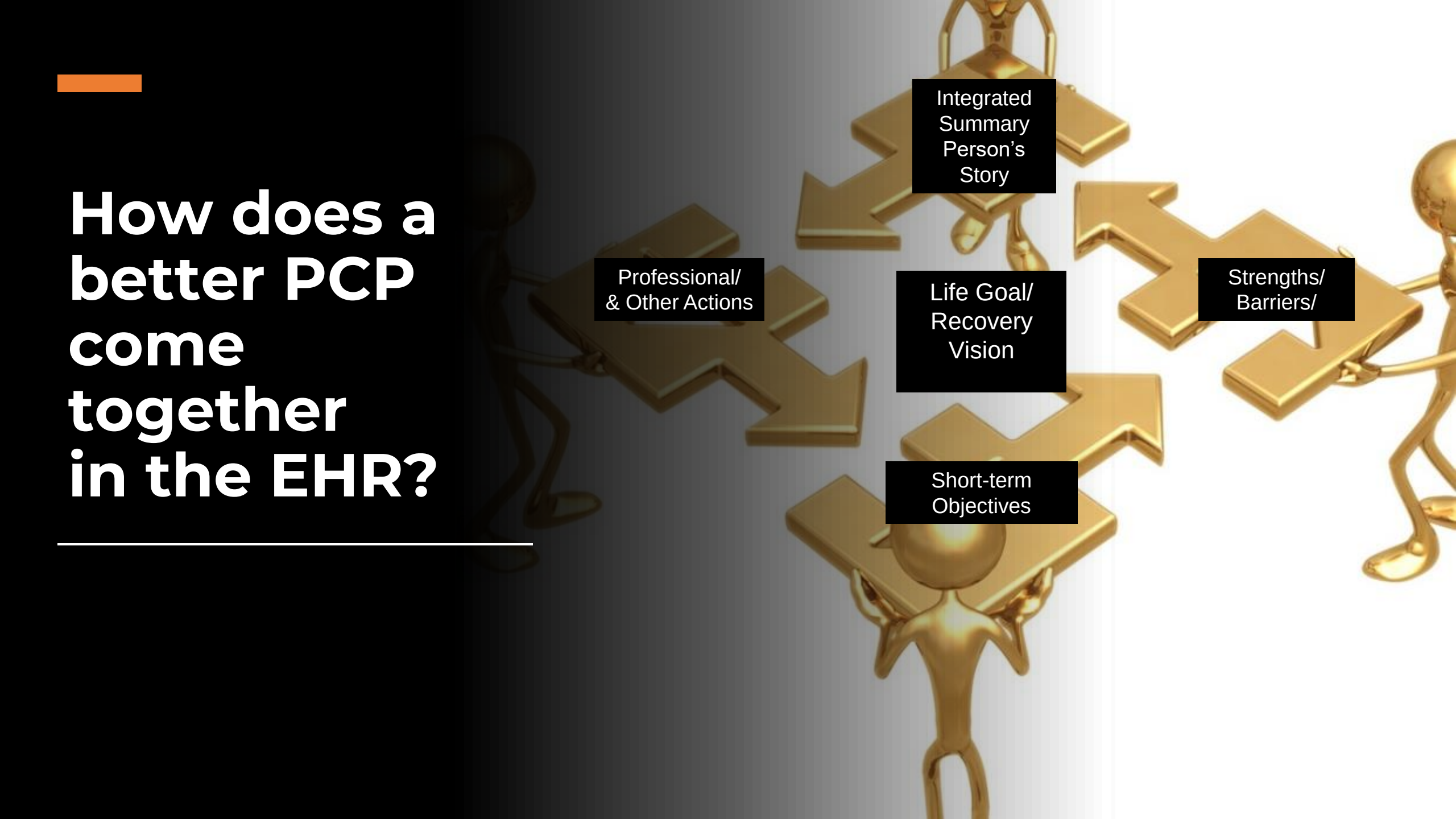
- Ideally a work group of users has been involved in design and testing. Use them to lead roll-out
- Pilot testing extensive use of test environment
- Need for content-related training AND technical navigation of the EHR
- Timing of training essential
- Structures to organize and support the GO LIVE transition including support from vendor
- Define documentation requirements as related to transition

Sample Tools and How to Use Them:

Create Before/After Examples

- Develop and use sample plans in initial and ongoing PCP workforce development
- It is helpful to show staff what you are trying to move away from – remember slide we showed you earlier! ☹
  - Staff may see their own habits in plan documentation in the “what to avoid” examples
  - Increases motivation/sense of urgency around change
- And also helpful to show them the vision of what you are trying to move toward
  - These kinds of prototype plans reinforce both quality PCP documentation AND the use of your EHR to achieve it ☺

How does a better PCP come together in the EHR?



Meet Mr. Blake

- 33-year-old African American man living in a shared-apartment program
- Enjoying his single longest period of living in the community after many hospitalizations and periods of time unhoused
- Wants to plan to move to his own apartment where he would have more control over many aspects of this life
- Many strengths to draw upon:
  - strong work ethic, some natural support connections (e.g., cousin), an improved relationship with his treatment team, ability to follow-through (e.g., persisting to achieve his GED), advocates for what he wants and needs
- Has been diagnosed with schizophrenia and often feels distressed by mental health issues.
- Isolated and rarely leaves his apartment for anything other than appointments; very uncomfortable around others; believes people are out to harm him in some way; these feelings intensified after the traumatic loss of his son to SIDS several years ago.
- He describes his mom as supportive, but their relationship is ‘strained” as she does not share his belief that his son was murdered.
- Desires to have better relationships with others (mom, friends, neighbors, etc.)

Newport County Community Mental Health Center

Treatment Plan

Long Term Goal: Long Term Goal(s) related to Social / Family / Spiritual / Relationships

Active: 07/20/2019 - 01/20/2020

"I don't want to be alone anymore. I want to have friends and family in my life."

Short Term Goal: Short Term Goal(s) related to Social / Family / Spiritual / Relationships

Active: 07/20/2019 - 10/20/2019

1) Mr. Blake will participate in a minimum of two social activities per week outside his home each week for the next 3 months as evidenced by report of Residential Counselor

Intervention: Services provided by NMH staff

Start Date: 07/20/2019 Frequency: 2x/month Person Responsible: Therapist

1) Jane Arsenal, Clinician, will provide Trauma-Informed Individual Therapy, 2x per month for 45 minutes for next 3 mos for the purpose of supporting Mr. Blake in processing the loss and trauma around the death of son and educating him regarding the event's impact on his relationships with others

Intervention: Intervention(s) related to Self Care / Developmental Issues

Start Date: 07/20/2019 Frequency: 2X/month Person Responsible: Community Integration Sp

2) Ed Manning, Community Integration Coordinator, will provide twice monthly, 90 minute Community Connections group for the next 3 months in order to help Mr. Blake identify and access social and recreational outings which fit with his preferred interests and which allow him opportunities to practice social skills in-vivo

Intervention: Med staff will provide up to date verbal & written educational material about current meds to client.

Start Date: 07/20/2019 Frequency: Weekly Person Responsible: PeerCoordinator

3) Sam Narrato, Peer Coordinator, will meet with Mr. Blake one-time weekly for 60 minutes for the next 2 months to assist him in completing a Wellness Recovery Action Plan in order to identify simple , safe, effective strategies for managing distressing symptoms which lead to social isolation.

Intervention: Clinician will assist client to develop positive coping skills appropriate for management/reduction of target sx

Start Date: 07/20/2019 Frequency: 2x/month Person Responsible: Clinical Coordinator

4) Sally Rodriquez, Clinical Coordinator, to provide twice monthly 60 minute Family session for 6 months to Mr. Blake and his mother, in order to assist them in rebuilding their relationship and in exploring ways Mr. Blake and his mother can spend time together.

Intervention: Clinician will assist client to develop positive coping skills appropriate for management/reduction of target sx

Start Date: 07/20/2019 Frequency: One time Person Responsible: Self Directed

5) Mr. Blake will call his mother within one week to invite her to meet with Sally Rodriguez, Clinical Coordinator (Self-directed action).

Intervention: Clinician will assist client to develop positive coping skills appropriate for management/reduction of target sx

Start Date: 07/20/2019 Frequency: Monthly Person Responsible: Natural Support

6) Ronnie P. Mr. Blake's cousin, has agreed to accompany him to the monthly pot-luck dinners in his housing complex so he can have an opportunity to meet new people and practice coping and social skills (Natural support action)

Closing Q&A… Your Thoughts and Ideas

Contact Us

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