At least someone is happy about all this…

Meanwhile, the rest of us…

The show must go on…

Thank you for being here…

And please be SAFE!

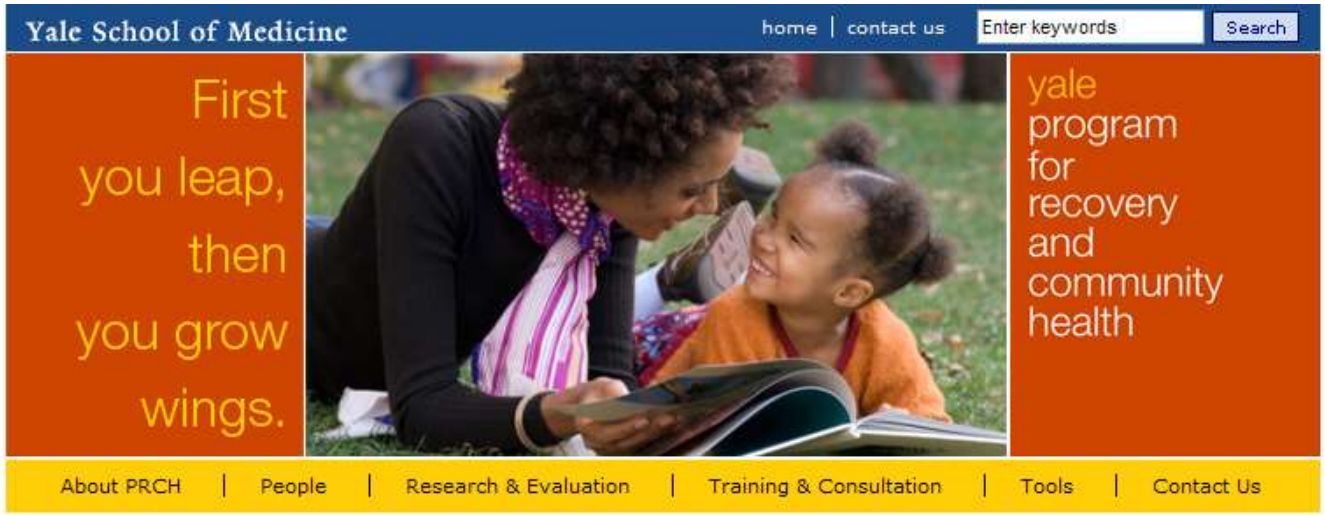
From Theory to Practice in Person Centered Recovery Planning

Janis Tondora, Psy.D.

Kentucky Targeted Case Management Conference

March 5, 2015

Introductions and Background



Yale Program for Recovery and Community Health
Erector Square, Bldg. One
319 Peck Street
New Haven, CT 06513

Busi Office:
64-7594
4-7582
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The Yale Program for Recovery and Community Health (PRCH)

The Yale Program for Recovery and Community Health, located at Erector Square in New Haven, CT, does collaborative research, evaluation, education, training, policy development, and consultation. We work to transform behavioral health programs, agencies, and systems to be culturally responsive and re-oriented to facilitating the recovery and social inclusion of the individuals, families, and communities they serve.

We seek to promote the recovery, self-determination, and inclusion of people experiencing psychiatric disability, addiction, and discrimination through focusing on their strengths and the valuable contributions they have to make to their communities.

Directions to our offices

VISIT US:
The Parachute Factory exhibit, *Out of House and Home*, through 2/2010.
Directions to our offices

JOIN:
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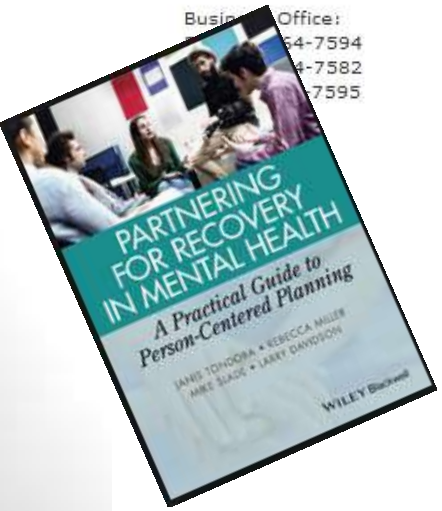
LEARN:
New Book:
A Practical Guid
Recovery-Orie
Practice: Tool
Transformin
Care

New Resource:
Getting in the Driver's Seat of Your Treatment: A Toolkit for Person Centered Care (.pdf)



The Current Reality of Treatment Systems

What we hope for THEM…

- ✓Compliance with treatment
- ✓Decreased symptoms/Clinical stability
- ✓Better judgment
- ✓Increased Insight…Accepts illness
- ✓Follows team's recommendations
- ✓Decreased hospitalization
- ✓Abstinent
- ✓Motivated
- ✓Increased functioning
- ✓**Residential Stability**
- ✓**Healthy relationships/socialization**
- ✓Use services regularly/engagement
- ✓Cognitive functioning
- ✓Realistic expectations
- ✓Attends the job program/clubhouse, etc.

What we value for US…

- ✓Life worth living
- ✓A spiritual connection to God/others/self
- ✓A real job, financial independence
- ✓Being a good mom…dad…daughter
- ✓Friends
- ✓Fun
- ✓Nature
- ✓Music
- ✓Pets
- ✓**A home to call my own**
- ✓**Love…intimacy…sex**
- ✓Having hope for the future
- ✓Joy
- ✓Giving back…being needed
- ✓Learning

Beyond US and THEM

- People with mental health and addictions issues generally want the exact same things in life as ALL people.

- People want to thrive, not just survive…
- PCRP challenges us to move past the “us/them” dynamic and embrace the true pursuit of **RECOVERY** rather than the maintenance of clinical stability

The Person-Centered Train: Who's on Board ☺ ?

Why "Person-Centered" Care?

- Broader disability rights movement: Professionals, Self-Advocates, Family Members
  - Established, effective models in use for decades, e.g., MAPS, PATH, ELP
- A national healthcare agenda to deliver "patient-centered" medicine
  - IOM, JCAHO, CARF, AACP, ACA
- The voice of consumer advocates; psychiatric survivors
  - *You keep telling me I am in should be in the "driver's seat of my treatment and my life…but half the time I am not even in the damn car!"*
- The challenge to offer culturally-responsive services
  - Need to tailor to individualized, cultural worldviews and to tap non-traditional supports prn

Why "Person-Centered" Care?

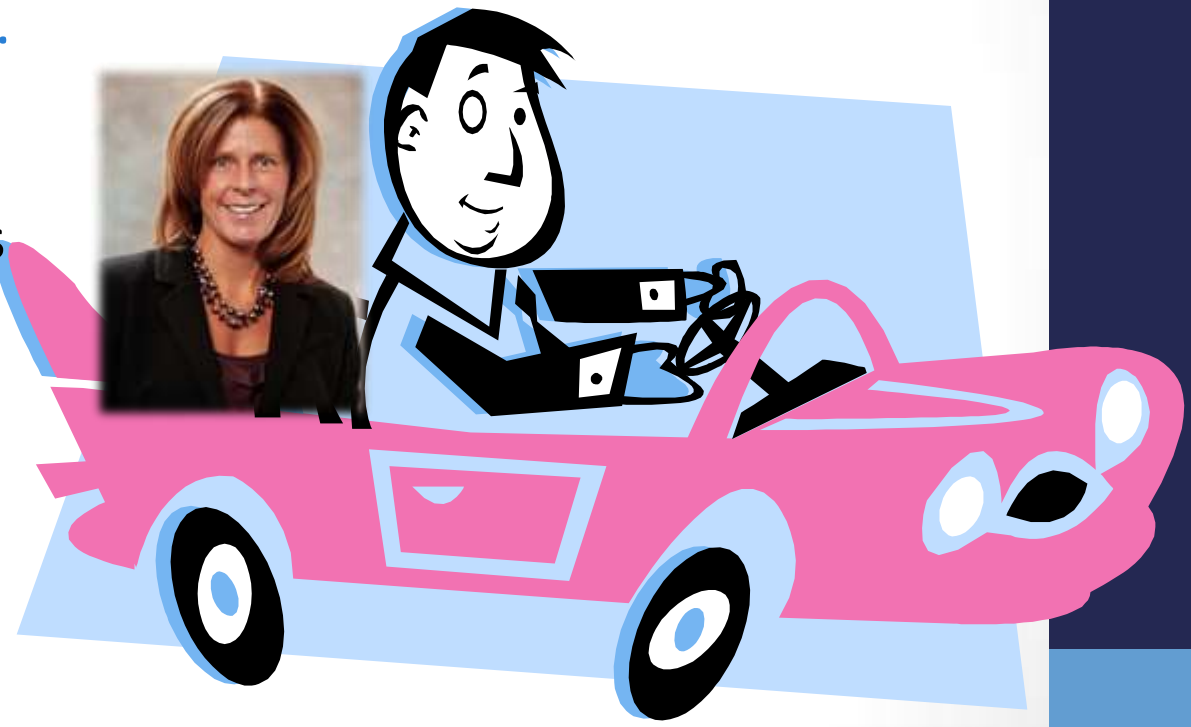
- Consistent with other national, State, and local "Recovery-Based" Initiatives
  - e.g., EBPs, Supported Employment, Psychiatric Advance Directives, consumer-directed recovery tools (WRAP, etc.)
- Legal foundations, e.g. individuals rights to self-determination and community inclusion in least restrictive environment
  - ADA, discrimination laws, Olmstead, Patient Self Determination Act
- Emerging research evidence showing PCRP leads to better OUTCOMES
  - Quality of life, increased engagement in/satisfaction with service systems, decreased hospitalization, increased community tenure
- An emphasis on values-driven treatment…
  - **It's simply the RIGHT THING TO DO!**

So, What Gets in Our Way? Common Concerns in PCRP:

1. If given choice, people will make BAD ones
2. Payers won't let us do this; regs prohibit this
3. The forms/templates/EHRs don't have the right fields
4. Consumers aren't interested/motivated
5. It devalues clinical expertise; violates professional boundaries
6. Its what the clubhouse does…Not a part of core clinical work
7. Lack of time/caseloads too high/ "initiative fatigue"
8. "My clients are too sick/impaired"
9. It doesn't fit with focus on evidenced-based practices
10. Don't we already do PCRP? Is it really any different?

If the person is in the driver's seat of their care, where does that leave me?

- 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
- TCM plays a vital role in coordinating the Circle of Support



Are some people "too sick" to engage in PCRP?

Perception

- Service users are too sick to engage in this kind of partnership; have no goals; are unrealistic; comfortable in "system"

Reality

- Over 30 years of accumulating evidence supporting the possibility of recovery
  - Davidson, L, Harding, C., & Spaniol, L. (Eds). (2006). *Recovery from severe mental illnesses: Research evidence and implications for practice.*

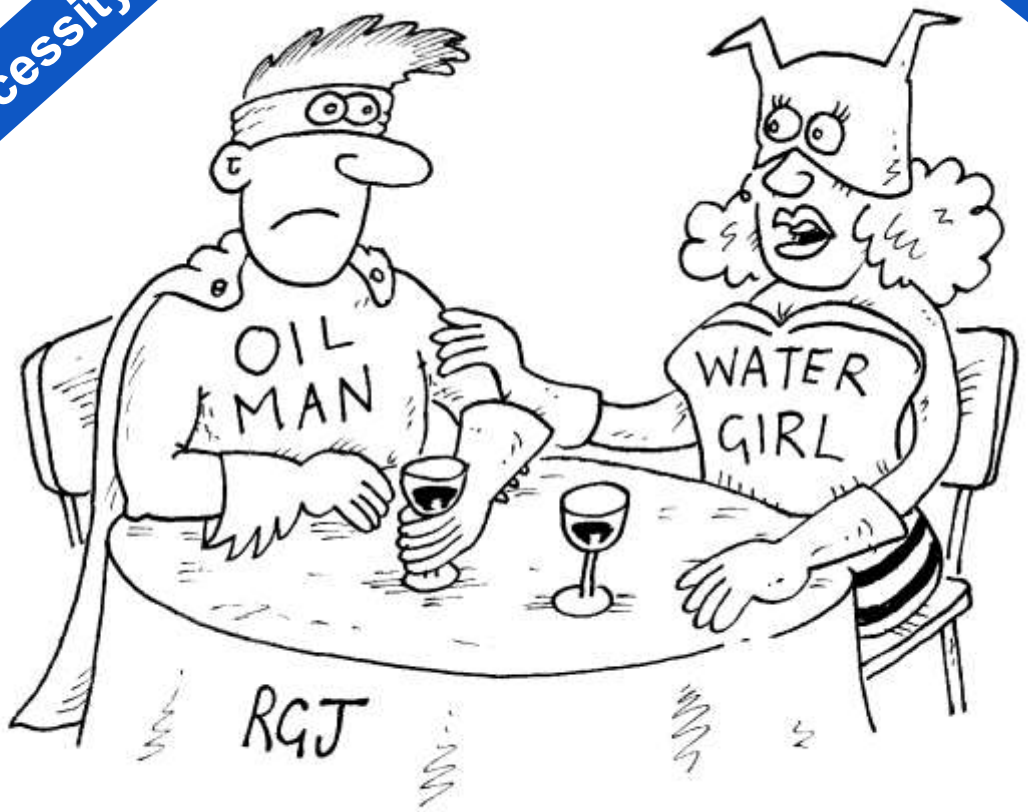
Can we write a plan that honors the PERSON and still satisfies the CHART?

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

- Can we balance medical necessity and compliance expectations with what it means to be “person-centered?”

Medical Necessity

Person-Centered Care

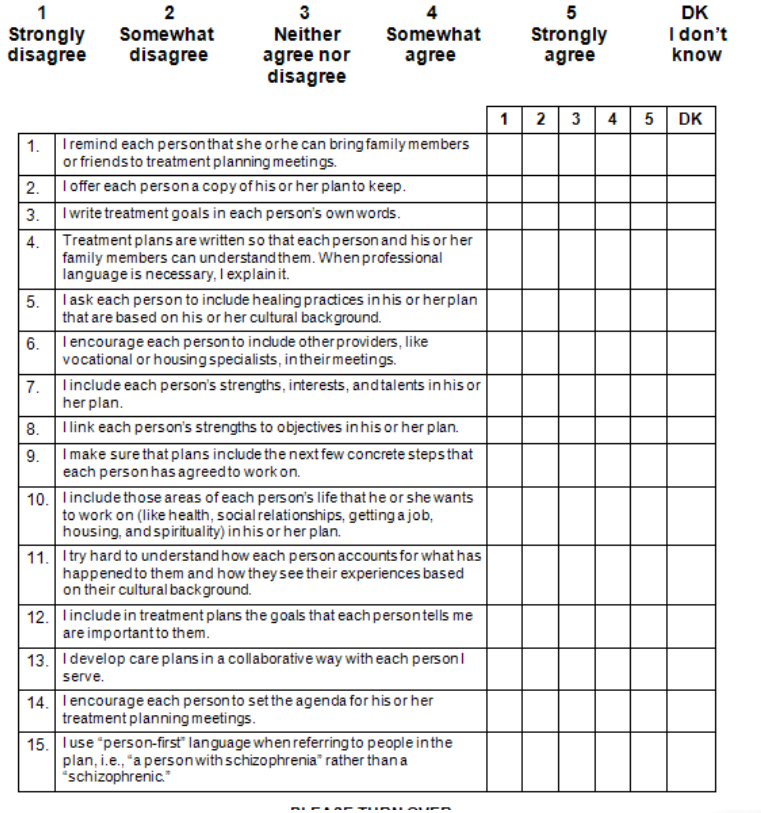


"Let's face it: Our relationship is doomed!"

PCRP:
Is it REALLY any different?

YES!

- In the experience of the persons served
- when we "take stock" of current planning practices
- and in the written recovery plan itself…



1 Strongly disagree	2 Somewhat disagree	3 Neither agree nor disagree	4 Somewhat agree	5 Strongly agree	DK I don't know

		1	2	3	4	5	DK
1.	I remind each person that she or he can bring family members or friends to treatment planning meetings.						
2.	I offer each person a copy of his or her plan to keep.						
3.	I write treatment goals in each person's own words.						
4.	Treatment plans are written so that each person and his or her family members can understand them. When professional language is necessary, I explain it.						
5.	I ask each person to include healing practices in his or her plan that are based on his or her cultural background.						
6.	I encourage each person to include other providers, like vocational or housing specialists, in their meetings.						
7.	I include each person's strengths, interests, and talents in his or her plan.						
8.	I link each person's strengths to objectives in his or her plan.						
9.	I make sure that plans include the next few concrete steps that each person has agreed to work on.						
10.	I include those areas of each person's life that he or she wants to work on (like health, social relationships, getting a job, housing, and spirituality) in his or her plan.						
11.	I try hard to understand how each person accounts for what has happened to them and how they see their experiences based on their cultural background.						
12.	I include in treatment plans the goals that each person tells me are important to them.						
13.	I develop care plans in a collaborative way with each person I serve.						
14.	I encourage each person to set the agenda for his or her treatment planning meetings.						
15.	I use "person-first" language when referring to people in the plan, i.e., "a person with schizophrenia" rather than a "schizophrenic."						

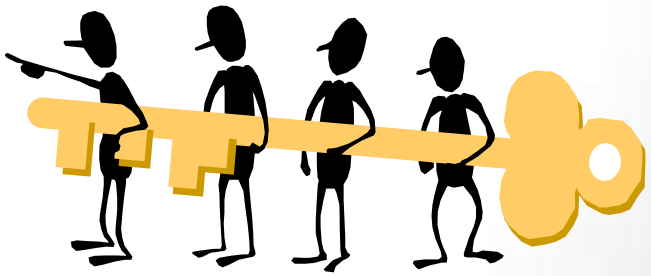
Person-Centered Care Questionnaire: Tondora & Miller 2009
http://www.ct.gov/dmhas/lib/dmhas/publications/PCCQprovider.pdf
http://www.ct.gov/dmhas/lib/dmhas/publications/PCCQperson.pdf

Person-Centered Care… a fuzzy concept?

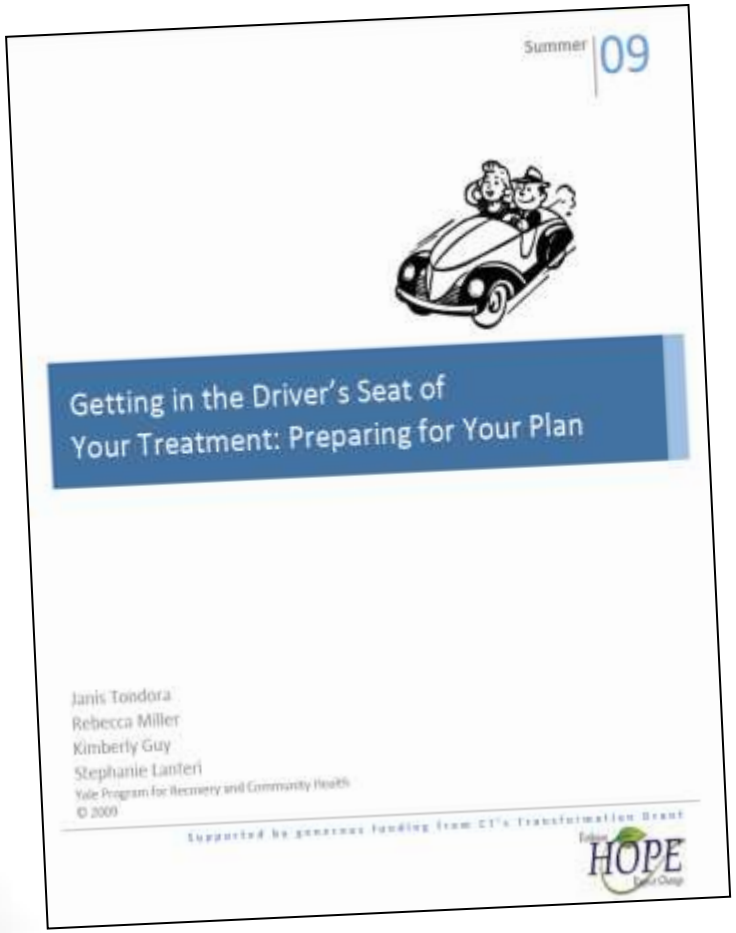
- *Consumers demand it, public service systems endorse it, medical and professional programs are encouraged to teach it, and researchers investigate it. Yet, people struggle to understand exactly what "It" is and what "It" might look in practice.*
    - Tondora et al., 2005, Implementation of Person-Centered Care and Planning: How Philosophy Can Inform Practice
- PCRP represent a unique opportunity to move from person-centered THEORY to person-centered PRACTICE

Sample Key Practices in the Process of PCRP

- Person is a partner in all planning activities/meetings; advance notice
- Person has reasonable control over logistics (e.g., time, invitees, etc.)
- Person offered a written copy
- Education/preparation regarding the process and what to expect
- Meeting ground-rules may shift
- Strengths-based assessment and language as a key practice



Educate and Prepare the Person in Recovery:



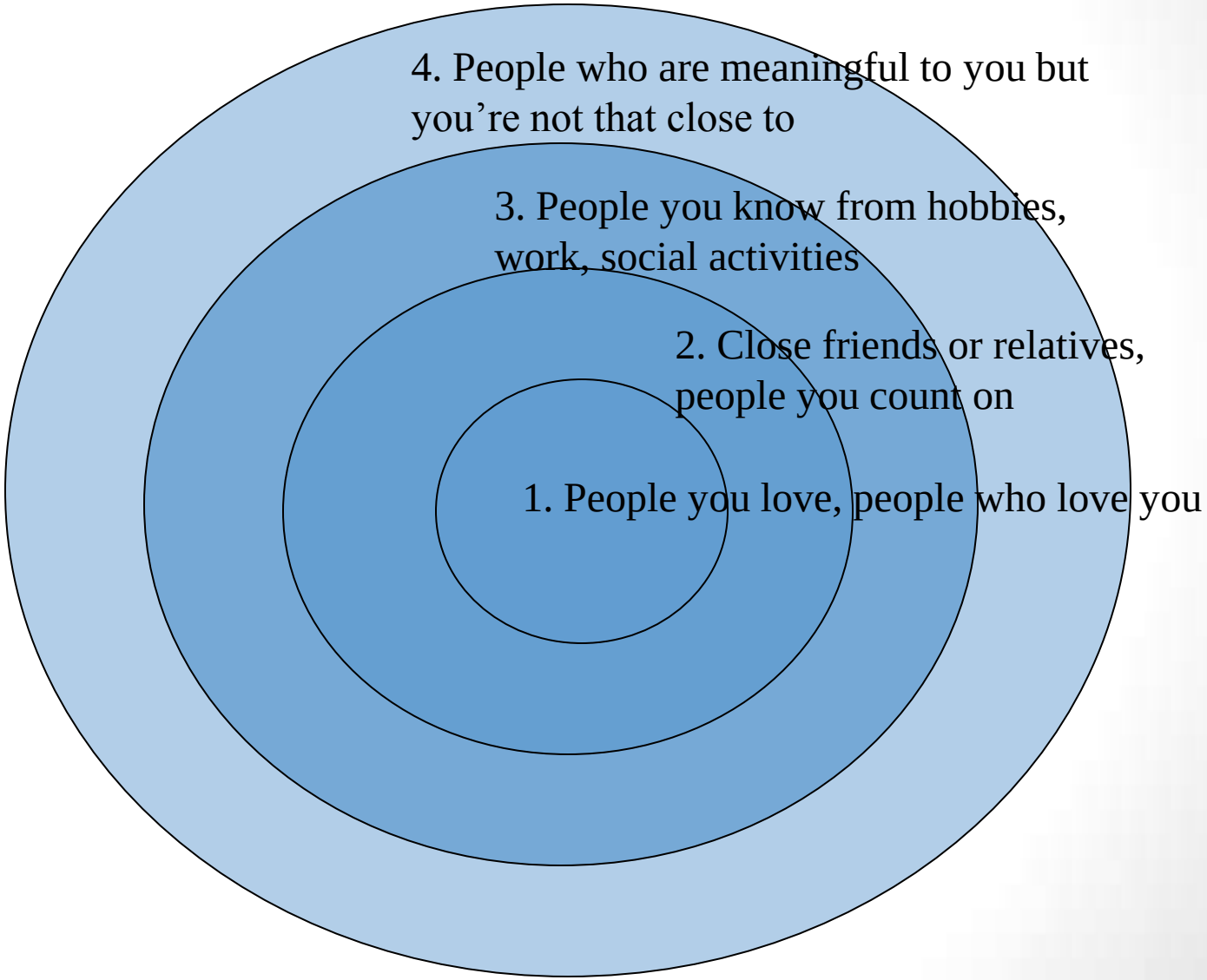
This toolkit can be useful for anyone – regardless of whether they have a psychiatric condition or an addiction. Everyone needs help at times setting goals, and figuring out what they want. This toolkit has some specific parts that are helpful to people with a mental illness or addiction, but could be really used by anyone.

-Janis Tondora
-Rebecca Miller
-Kimberly Guy
-Stephanie Lanteri

Yale Program for Recovery and Community Health, © 2009

- http://www.yale.edu/PRCH/documents/toolkit.draft.3.5.11.pdf

Build a Recovery Team
A Place Where TCM Plays a Vital Role!



Consider the Value of "Peer Services"

- *The peer-to-peer model is an exceptional example of the innovative ways in which we can help the system overcome its own barriers. Peer-support programs are not just empowerment programs.*

  They are an expression…
  and an example…of the way the system is going to have to fundamentally change to foster healing relationships, and create an environment conducive for recovery."

  - A. Kathryn Power, CMHS

Structure and Roles in Planning Meetings

- Treatment Team members arrive on time; introductions
- The person is given the team's full attention, e.g., cell phones are turned off; there are no side-bar conversations; team member's are not completing/reading other paperwork/texting/ responding to e-mail, etc.
- The person is not "talked about" during the meeting. All comments and questions are directed first to the individual and are a collaborative exchange between the person and his/her Treatment Team.
- "What comes next" is explained to the person, including an opportunity for them to review the plan; provide input

The Role of Strengths-Based Inquiry

- “It’s about what’s STRONG, not just about what’s WRONG! “
    - Gina, a former patient at a state psychiatric hospital
- Strengths are not meant to sit on a shelf!

Be Mindful of the Power of Language in Recovery Planning

- For the last 18 mos., the patient has been compliant with meds and treatment. As a result, she has been clinically stable and has stayed out of the hospital. However, patient has no-showed for last two visits and the team suspects she is flushing her meds. Patient was brought in for evaluation by the Mobile Crisis Team today after she failed to report to Clozaril clinic for bloodwork.

- In the last 18 months, Sandra has worked with her psychiatrist to find meds that are highly effective for her and she has been active in activities at the clinic and the social club. Sandra and her Team all feel as though she has been doing very well, e.g., returning to work, spending time with friends, and enjoying her new apartment. However, people have become concerned lately as she has been missed at several activities, including a bloodwork appointment at today's clozaril clinic. The Mobile Outreach Team did a home visit to see if there was any way the clinic staff could assist her.

Community Life: What does it have to do with *Recovery??*

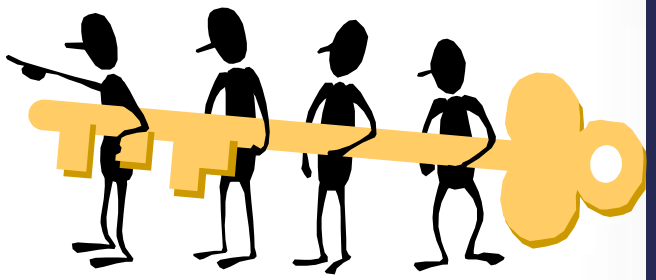
EVERYTHING! If we listen to the voice of people in recovery…

- *There is this little pub down the street that I just love. I like to go there and have a tonic and lime and just chat with the patrons. I am not sure what it is about that place?? But it makes me feel good. Maybe…maybe it's a lot like 'Cheers' – you know, a place where everybody knows my name… I am just Gerry, period. Not "Gerry the mental patient…"* **(Man in recovery on finding his niche…)**
- Not what comes AFTER one is stable
- NOT something we can artificially create FOR people

Key Practices in Self-Determination

SELF-DETERMINATION

- service users lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life.



  - You'll know you're doing it when…
  - What you'll hear from people in recovery…
    - *This time, with a PAD (psychiatric advance directive), I did not receive any treatments that I did not want... I really felt like the hospital took better care of me because I had my PAD. In fact, I think it's the best care that I've ever received.*

Risk vs. Safety

- A person-centered, recovery orientation in no way conflicts with risk assessment and encourages the appropriate use of this technology.
- Restrictive measures only used when there is ***imminent risk*** as narrowly allowed under statutory law – this typically involves safety issues
- PCRP encourages responsible “risk taking”

Risk vs. Safety

“We’ve considered every potential risk except the risks of avoiding all risks.”

Finding the Recovery Zone in PCRP

Let person do what he/she wants regardless of our concerns. This is not being person-centered; this is

Neglect

Get the person to do what WE want regardless of their viewpoint. This is not acting in their best interest; this is

Coercion

http://www.patdeegan.com/AboutCommonGround.html

So you try your best to implement ALL of these "key practices," but how do we move from the

PROCESS of PCRP to the

DOCUMENTATION of PCRP?

So, how do all the pieces come together in the written recovery plan?

…in a way that balances the spirit of person-centered care with the rigor required in clinical documentation?

Regulations
Required Paperwork
Medical Necessity
Compliance

Collaborative
Person-Centered
Strengths-based
Transparent

and in a way that doesn't BURY you !!

"Apparently, Smith's desk just couldn't withstand the weight of the paperwork we piled on his desk."

Putting the Pieces Together In a PCRP Document

GOAL
as defined by person;
what they are moving "toward"…not just eliminating

Strengths/Assets
to Draw Upon

Barriers /Assessed Needs
That Interfere

Short-Term Objective
S-M-A-R-T

Interventions/Methods/Action Steps
- Professional/"billable" services
- Clinical & rehabilitation & TCM Care Coord
- Action steps by person in recovery
- Roles/actions by natural supporters

Goal Setting in Person-Centered Planning

Video clip…The Gestalt Project

http://www.youtube.com/watch?v=QficvVNIxTI&feature=youtu.be

Goals: What Do People Want?

Independence

I want to control my own money.

Work /education

I want to finish school

Spiritual issues

I want to get back to church.

Health/well-being

I want to lose weight.

Housing

I want to move out of the group home.

Social activities

I want to join a bowling league.

Satisfying relationships

I want to see my kids.

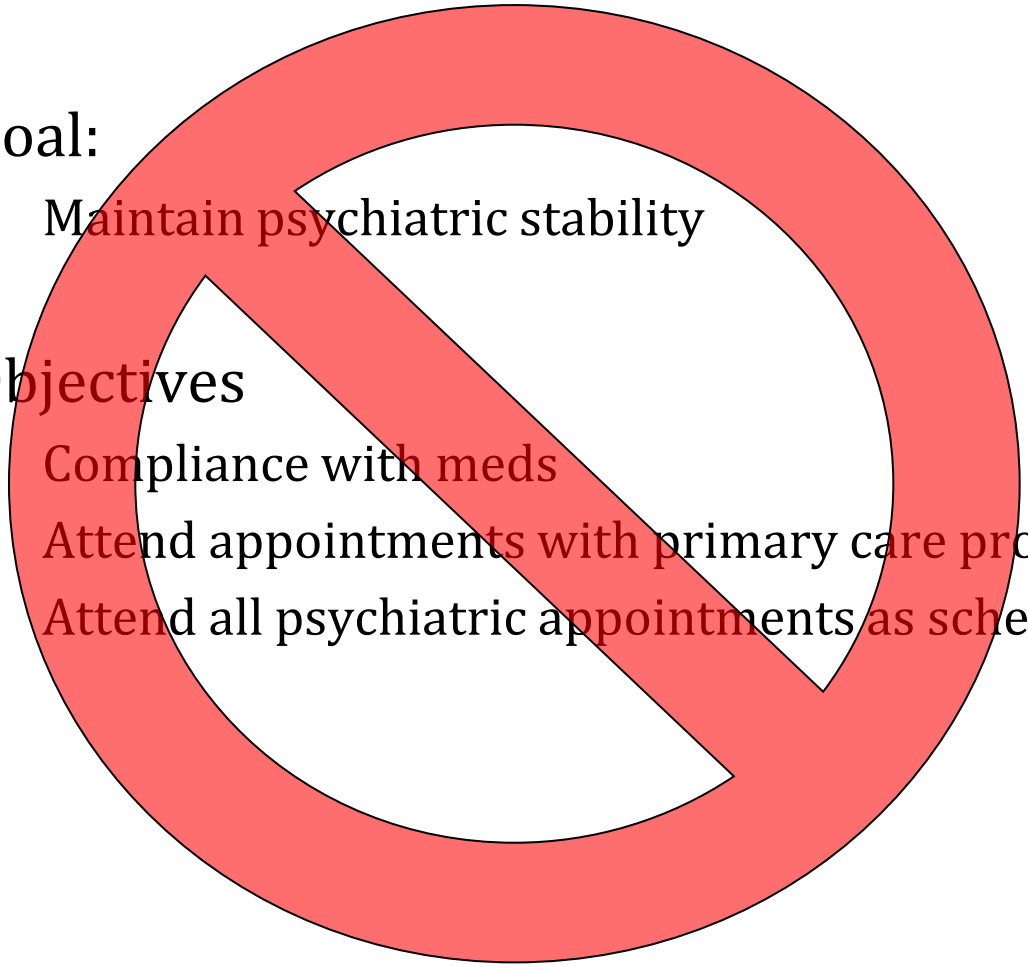
Valued Roles

I want to volunteer at the Senior Center.

To be part of the life of the community…

And not just the territory of traditional treatment plans

- Goal:
  - Maintain psychiatric stability
- Objectives
  1. Compliance with meds
  2. Attend appointments with primary care provider
  3. Attend all psychiatric appointments as scheduled



Active Use of Assessed Strengths

- Focus on strengths and assets that can be leveraged in the person's Recovery Plan, i.e., strengths are not meant to "sit on a shelf"

- …a person with a love for books might be engaged by asking him/her to help out in the agency resource center…a person who loves music might benefit from access to CDs/headphones as a way to self-sooth… a teenager with a love of animals might volunteer at the dog shelter…a spiritual person might desire support from a faith rep or an agency chaplain… an individual with a strong connection to their cultural heritage might work on communications skills by becoming part of the cultural competence committee

Barriers/Assessed Needs

- **What's getting in the way?**
  - need for skills development
  - Intrusive symptoms
  - lack of resources
  - need for assistance / supports
  - problems in behavior
  - challenges in activities of daily living
  - threats to basic health and safety
  - **challenges/needs as a result of a mental/ alcohol and/or drug disorder/SED**

Objectives should be SMART

- An objective is a meaningful step (in the eyes of both the person & staff) toward the longer term goal; a concrete change in functioning or behavior
  - Simple or Straightforward
  - Measurable
  - Attainable
  - Realistic
  - Time-framed

Objectives Should NOT be Limited to Service Participation

- **GOAL: I want to find a girlfriend.**
- **Objectives: NOT -** Patient will maintain medication compliance, attend social skills group, and meet with his/her therapist but…Stan will…
  - Within one week, identify 3 local places in the community she/he can go to meet others
  - Within 30 days, demonstrate 3 positive coping strategies to manage anxiety in social situations.
  - Participate in one preferred social activity outside the group home per week for the next 90 days
  - Demonstrate 3 "conversation-starters" in session with clinician within 2 weeks
  - Even use conversation starters to invite someone on a date!

A Note of Caution…

Sometimes we hold the bar unreasonably HIGH… or make the timelines unreasonably LONG

- *RECOVERY MAY BE A JOURNEY; BUT IF YOU NEVER GET ANYWHERE, IT CAN EASILY FEEL LIKE A TREADMILL*
  - (Joe Marrone, Institute for Community Inclusion)

Services/Interventions

- Professional services must specify…
  - WHO will provide the service, i.e., name and job title
  - WHAT: The TITLE of the service, e.g., Health & Wellness Group
  - WHEN: The SCHEDULE of the service, i.e., the time and day(s)
  - WHY: The individualized INTENT/PURPOSE of service

Language of TCM Interventions – How is it Unique?

Direct Service Provision, e.g., under MRO Medicaid Rehab Option	Case Management under TCM Targeted Case Management
Teaching self administration of medications	Monitoring self administration of medication
Coaching client how to access public transportation	Coordinating medical care and transportation
Teaching client how to budget and run a household	Monitoring budget to maintain ability to live in community
Educating client on how to obtain needed services	Maintaining housing. Coordinating and planning housing resources
Educating client on Health and Wellness	Monitoring client's adherence to nutritional plan

Action Steps by The Person In Recovery & Natural Supporters

- Traditionally, interventions in a plan include only those performed by staff. The recovery model, however, emphasizes the responsibility of a person to participate actively in his or her own care as well as the benefits of seeking contributions of "natural supports" (e.g., family, friends, advocates, & community supporters)
- For each objective, consider specifying:
    - "Personal Actions" (this promotes a sense of self-agency and helps to activate people in their recovery) and
    - "Natural Support Action" (to help the person build/expand their natural recovery network as a supplement to professional services)

Outpatient Example
Meet Greg

- Greg reports he is very lonely. 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… Although he would like a girlfriend, Greg admits to being "terrified" to get out in community and meet women, and states that its been 10 years since he dated anyone. He wouldn't know where to start…He is currently unable to take the bus and is afraid to go anywhere alone because he often gets confused or fears others might try to hurt him.

Which of the below is the best goal statement for Greg's PCRP?

1. I don't want to feel like a "zombie."
2. Greg will better manage distressing symptoms of paranoia.
3. I want a girlfriend.
4. Greg will voluntarily attend the Social Skills Group.
5. I just want to be happy.

Snapshot:
A Traditional Treatment Plan

- Goal(s):
  - *Achieve and maintain clinical stability; increase reality testing and decrease paranoia; comply with medications*
- Objective(s):
  - Patient will attend all scheduled groups in program; patient will meet with psychiatrist and take all meds as prescribed; patient will complete symptom management program; patient will demonstrate increased insight re: schizophrenia
- Services(s):
  - Psychiatrist will provide medication management; Social Worker will provide Symptom Management; Nursing staff will monitor medication compliance; Rehab Staff will provide Illness Education

Uh, excuse me…

I'm here to return YOUR goals.
You left them on MY recovery plan!

- Take my clozaril
- Increase insight
- Reduce paranoia
- Attend group

Greg's PCRP

- **Goal: I want a girlfriend… someone to share my life with.**

- Strengths:
  - Motivated to reduce social isolation; supportive brother; has identified community he enjoyed in past interests(e.g., music, Chinese restaurants) well-liked by peers; humorous

- Barriers/Assessed Needs/Problems:
  - Intrusive thoughts/paranoia increase in 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 symptoms management/coping strategies, improve communication and social skills, attend to personal appearance

- Objective:
  - Greg will effectively use learned coping skills to manage distressing symptoms to participate in a minimum of 1 preferred social activity per week for the next 90 days

Services & Supports

- Jane Roe, Clinical Coordinator, to provide CBT 2X/mos. for 45 min for next 3 mos. to increase Greg's ability to cope with distressing symptoms in social situations (teaching thought stopping, distraction techniques, deep-breathing, visualization, etc.)
- Dr. X to provide Med Management, 2X/mos for 30 min for next 3 months to evaluate therapeutic impact and possible side effects to reduce fatigue and optimize functioning
- John Smith, Case Manager, will complete referral to travel training program within 2 weeks to help him become independent with city bus (e.g., identifying most direct bus routes, rehearsing use of coping skills, role playing conversations if confused/lost, etc.)
- Greg's brother, Jim, will accompany Greg to weekly social outings over the next 3 months.
- Greg will complete a daily medication side-effect log for the next 2 months while meds are evaluated and adjusted.

And Another…Meet Chris

- Outpatient services 5 years due to depression with suicidal thoughts
- Low energy and impaired concentration when severely depressed; has neglected bill payment in the past (evicted)
- Moved in with brother after hospitalization 5 years ago on condition he have a money manager/conservator
- Lived with brother for 2 years; past 3 years has been in apartment of his own
- Engaged in treatment; using meds effectively as tool in his recovery; sx stable
- Money continues to be controlled by the Conservator who pays his bills and gives him a weekly allowance.
- Chris wants to take control of his money; brother is supportive but worried
- Also wants a part-time job but is very concerned about the impact of income on benefits; used to work as a library assistant but now interested in physical activity. Enjoys the outdoors; considering landscaping. Unsure how to begin job search.

Chris PCRP

- **Goal: I want to make money…get a part time job.**

- Strengths:
  - Successful independent living x 3 years; supportive brother; motivated to resume control of money; has work history and current interests (enjoys physical activity)

- Barriers/Assessed Needs/Problems:
  - Major depression leads to lack of energy/initiative/lack of concentration/ difficulty leaving house and following through on tasks; in past has neglected personal tasks (bill payment) when experiencing symptoms (currently has conservator and weekly allowance); previous hospitalization for suicidal thoughts (none at present time);confused/fearful about impact of earnings on benefits

Objective #1 - *Chris will have increased control over his money as evidenced by his successfully budgeting a monthly (rather than weekly) personal allowance over the next 6 months.*

Services & Supports

- CM will arrange meeting with Conservator within 30 days to negotiate plan to gradually increase Chris' responsibility for his money. Ongoing weekly phone calls with Conservator to discuss/monitor Chris's progress.
- CM will meet with Chris twice monthly to monitor his response to clinical interventions and coordinate care with clinical supporters.
- CM will meet with Chris and his brother within 2 weeks to discuss Chris' financial goals and plan. Weekly calls with brother to address concerns and brainstorm ways brother can help Chris in assuming control of his money.

Objective #2 - *Within 2 months, Chris will have a written plan showing how much money he can earn and resulting impact on financial benefits.*

Services & Supports

- CM to complete referral to Connect to Work (CTWC) Center within 30 days. At conclusion of Benefits Counseling, meet with Chris and CTWC Contact to review Chris' plan and ensure his questions/concerns are answered.

Objective #3 - *Within 6 months, Chris will have identified, and visited the sites of, at least 3 potential job types he might like to pursue for work.*

Services & Supports:

- CM to meet with Chris and Vocational Coordinator one time/month to discuss Chris' progress toward job search and to address any identified vocational needs.
- CM will meet with Chris twice monthly to monitor his response to clinical interventions and coordinate care with clinical supporters

In Conclusion…

- You CAN create a recovery plan which honors the person and satisfies the chart!
- This is central in your partnership with individuals so you can help them move forward in their recovery in the community of their choosing!
- *We just need to stop accepting what is and start creating what should be…* Dale DiLeo
  - How will YOU be a part of change moving forward?

For more information:

Janis Tondora:

janis.tondora@yale.edu