New England (HHS Region 1)

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Promoting Person-Centered Planning within New England Through Learning Collaborative Supports: From Theory to Practice

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Introduction

The New England Mental Health Technology Transfer Center (MHTTC) has as its overarching aim *"using evidence-based means to disseminate evidence-based practices"* to mental health providers across the region to promote the resilience and recovery of persons at risk for, living with, or recovering from mental health challenges and their loved ones. In addition, we are committed to proactively advancing social justice and racial equity, as well as the provision of culturally and linguistically appropriate behavioral health services to all residents of the New England region.

The New England MHTTC offers training and technical assistance (T/TA) at the local, regional, and national levels on recovery-oriented practices, including person and family-centered care planning and shared decision-making. To inform the specific topics offered for T/TA, the New England MHTTC conducted a needs assessment and discovered that one of the most sought-after topics of learning was strategies for maintaining a strengths-based, person-centered approach to collaborative planning while at the same time satisfying a myriad of documentation requirements associated with state regulations and funder expectations.

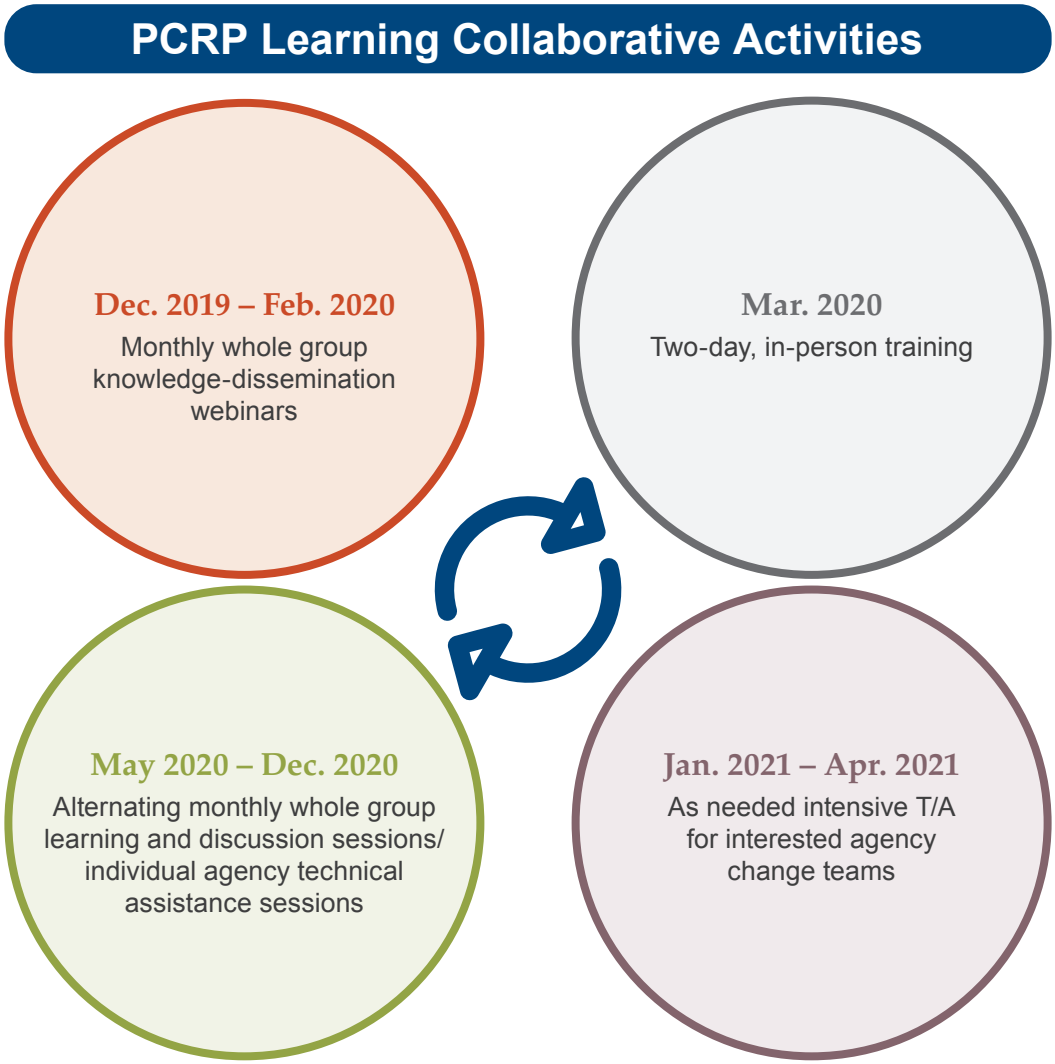
In order to respond to this regional need, in December 2019, the New England MHTTC launched a *Person-Centered Recovery Planning Learning Collaborative*. This learning collaborative was a multi-agency project to provide training, technical assistance, and implementation support around the practice of person-centered recovery planning (PCRP). Dr. Janis Tondora of the *Yale Program for Recovery and Community Health* and Dr. Dan Wartenberg of *Newport Mental Health* used their experience and expertise guiding mental and behavioral health agencies' implementation of person-centered recovery practices at various levels of care.

About Person-Centered Recovery Planning

Person-centered recovery planning (PCRP) has been recognized as a promising tool for transforming the current behavioral health system and restoring certain elementary freedoms to individuals receiving services and their loved ones (Institute of Medicine, 2001). Person-centered care involves a person-centered, strengths-based process that prioritizes the needs, goals, resources, and experiences of the person receiving care and includes all aspects of care from the moment an individual walks in the door. Person-Centered Recovery Planning (PCRP) is an ongoing process of collaboration between an individual and their professional providers and natural supporters that is aligned with the individual's preferences and results in the co-creation of a recovery-oriented care plan.

About the Learning Collaborative

The *Person-Centered Recovery Planning (PCRP) Learning Collaborative* ran from December 2019 until April of 2021, with five behavioral health organizations representing the states of Maine, New Hampshire, and Rhode Island, selected through a formal application process. Each agency convened a change team to attend a series of knowledge-dissemination webinars, a two-day in-person training, individual agency and small group technical assistance sessions, and whole group learning and discussion sessions over the course of the learning collaborative.



The participating agencies varied in size, funding mechanisms, readiness for change, existing exposure to recovery-oriented practices, and goals for implementation of person-centered recovery planning practices. The COVID-19 pandemic also introduced significant challenges that required increased flexibility from the trainers and participants, including a 3-month extension of support.

Agencies were encouraged to involve between 4-6 individuals in their change team representing the following types of roles: clinical supervisor/team lead, direct support practitioner, quality monitoring representative, person in recovery, peer supporter, rehabilitation specialist, cultural competence representative, agency executive leadership, and any project-specific personnel (e.g., information technology specialists if an agency was interested in redesigning assessment and planning templates within their Electronic Health Record). The number and type of active participants from each learning collaborative agency varied—this was especially true once the COVID-19 pandemic required agencies to quickly pivot service delivery to an online telehealth model. Agencies entered and left the learning collaborative with varying degrees of change in their use of PCRP practices, impacted by a variety of factors, which we discuss below.

Key Learnings

Through quantitative and qualitative evaluations, the New England MHTTC was able to identify areas of strength and improvement for future learning collaboratives and person-centered recovery planning knowledge dissemination. SAMHSA requires the MHTTC network to evaluate its programs using the Government Performance and Results Act (GPRA) measures, three brief questions that determine satisfaction, perceived benefit, and usefulness of the information delivered during a learning collaborative. *Person-Centered Recovery Planning (PCRP) Learning Collaborative* participants rated all three measures highly with average scores of 1.55, 1.45, and 1.50 respectively on a scale of 1-5 with 1 being the most positive response.

Question	Average Score*	Total # Responses
1. How satisfied were you with the overall quality of this event?	1.55	11
2. I expect this event to benefit my professional development and/or practice.	1.45	11
3. I will use the information gained from this event to change my current practice.	1.50	10

**Average scores are based on a scale from 1 to 5, with 1 being the most positive response.*

An independent evaluator who was not involved in the delivery or coordination of the *PCRP Learning Collaborative* conducted an hour-long focus group via Zoom with learning collaborative facilitators/staff and nine semi-structured 20-30-minute interviews via phone with participants from all five of the agencies in the learning collaborative. Going into these discussions, the evaluator had two underlying questions: 1) What was the impact/level of change achieved in the participating organizations as a result of the learning collaborative? and 2) How can a learning collaborative best be organized to optimize engagement and implementation efforts of the participating organizations?

Several themes emerged as facilitators and participants provided information that determined answers to these questions.

What was the impact/level of change achieved in the participating organizations as a result of the learning collaborative?

1. Impact of Person-Centered Recovery Planning Knowledge Gain on Agency Service Delivery

As the agencies had different implementation goals and processes from the beginning, they achieved different levels of change in implementing PCRP, from dissemination of information to achieving actual change in practice.

Implementation activities across agencies include:

- Dissemination of knowledge about PCRP language and approaches during supervisory conversations with staff (1 agency)
- Formal internal training to build competency around the philosophy, documentation, and practice of PCRP during orientation and existing staff trainings (2 agencies)
- Using PCRP knowledge and attitudes to inform the interview process for hiring new staff (1 agency)
- Creating and using new assessment and treatment planning tools aligned with PCRP, with a focus on modifying the EHR (2 agencies)

2. Commitment to Implementation Process as a Driving Force for Change

Participants noted that it takes more than a training or a meeting to build a consensus among all stakeholders, reduce potential reluctance around the adoption of new practices, and identify and address implementation barriers. Due to agency size, staff responsibilities, and differentiated roles within change teams, there was variable change around PCRP practices within the five agencies.

Facilitators and participants identified potential factors, related to level of commitment to the implementation process, that may have affected the amount of change observed:

- Time and resources each change team invested in PCRP implementation activities outside of learning collaborative sessions
- Investment of agency leadership in PCRP implementation
- Speed and complexity of implementing organizational change (determined in part by agency size and goals)
- Amount of additional support sought outside scheduled webinars and T/TA sessions (determined by depth of change sought)
- Time spent in internal, guided conversations around PCRP with staff
- Analysis and refinement of existing planning products/tools to align with the person-centered practices being promoted

Two of the five agencies who participated in the PCRP Learning Collaborative demonstrated greater change, in part due to 1) a larger investment of time and resources between learning collaborative sessions, 2) strong commitment to implement PCRP from agency leadership, 3) use of PCRP skills-training to strengthen staff competency agency-wide , and 4) provision of support on the implementation of more intensive PCRP practices (e.g., co-creation of the written PCRP plan) only after there had been significant effort building an understanding of the basic philosophy and principles of person-centered care.

3. Disruption of the COVID-19 Pandemic on Person-Centered Recovery Planning Implementation

The unprecedented circumstances of the COVID-19 pandemic were identified as a major factor that had a decisive impact on successful implementation of PCRP and on conducting the learning collaborative itself. Both the participants and the leadership team emphasized the detrimental impact of the COVID-19 pandemic on reducing organizations' initial levels of involvement in the PCRP implementation process and their commitment to the learning collaborative activities.

The pandemic caused disruptions in:

- Available time to devote to learning and implementation activities
- Momentum of change
- Agency staff and change team composition
- Ability to meet in-person, the more effective and engaging way to communicate

Because of these disruptions and the disproportionate impact COVID-19 had on the smaller agencies' abilities to pivot to virtual service delivery, facilitators adjusted their expectations of agencies' ability to implement various aspects of PCRP by the end of the learning collaborative. Accordingly, the structure and activities that had previously been determined for the learning collaborative were reconsidered and enhanced flexibility, including a longer but looser schedule for activities—as well as a pause during the month of April 2020—were introduced.

How can a learning collaborative best be organized to optimize engagement and implementation efforts of the participating organizations?

1. Existing Agency Characteristics that Supported Change

The learning collaborative facilitators found that the teams that had good horizontal and vertical representation and complementary roles in their implementation teams fared better in the implementation process. The most important factors that the participants and the leadership team of the learning collaborative identified as facilitators of PCRP implementation included having:

- An innovative and supportive organizational culture
- A diverse/mixed composition in the implementation team, with person in recovery involvement being particularly critical
- Both direct support staff and senior leadership buy-in and active involvement
- Higher organizational readiness and sense of urgency around change
- Funding and licensing standards which required the adoption of a PCRP approach, e.g., expectations of Certified Community Behavioral Health Clinics, the Centers for Medicare and Medicaid Services, the Commission on the Accreditation of Rehabilitation Facilities, state behavioral health authority program requirements, etc.

2. Organizational Readiness to Implement Person-Centered Recovery Planning

Agencies that had a prior investment in PCRP and entered the learning collaborative having decided to make a change, overall, progressed further in the implementation process. Both facilitators and participants were asked to rate their level of change at the beginning and end of the learning collaborative.

All five agencies reported that they started the learning collaborative at least in *contemplation stage,* perceiving the need to change or improve their practice. Two of the five agencies reported that they made progress to the *decision stage* by the end of the learning collaborative; two reported ending at the *implementation stage;* and one reported ending at the *maintenance stage.*

Four of nine interviewed people agreed with facilitators on the stages of change with which their agency/program started and ended the learning collaborative (44% mutual agreement). Three people agreed with facilitators' opinion on stage of change upon the completion of the learning collaborative (33% partial agreement), whereas 2 people estimated both their pre and post stages of change drastically differently from the opinion of the collaborative facilitators (22% disagreement). Facilitators reported that two of the five agencies made progress from the *decision* to *implementation stage;* two began in the *contemplation stage* but were unable to progress further; and one agency that began in the *decision stage* was unable to progress further.

3. Impact of Learning Collaborative Structure and Activities

The general impression was that the learning collaborative had a good mix of individual and group activities. The participants almost unanimously said that the 2-day intensive skills training in PCRP and individual monthly TA calls were the most useful components of the learning collaborative. They all agreed that the individual agency calls provided the most practical operational solutions and resources tailored to the specific needs of their agency for implementing PCRP.

> This is about managing people and the change process. And you know, this [PCRP] might sound good in theory, but really what does this look like in practice? Dan and Janis are able to have those conversations with me as the director.
>
> —PCRP Learning Collaborative participant

4. Importance of Mutual Learning Opportunities

Recognizing that the participating agencies were at different levels of implementation and readiness for change, and therefore had different needs, the participants' opinions were divided regarding the possibility of mutual learning. While some of the participants thought that being in a mixed group of agencies was a unique and inspiring opportunity to share experiences and learn from each other, others did not find the group meetings particularly useful to their efforts and learning and could not relate to the reporting and operations of the agencies that were too different from their own in terms of size, structure, and PCRP

implementation needs. The learning collaborative leadership recognized the benefits of having a mixed group of people as an opportunity for cross-fertilization and positive peer pressure but acknowledged that meeting the needs of such a diverse group of agencies that were on the opposite sides of the implementation continuum occasionally represented a challenge.

5. Facilitator and Staff Characteristics

All the participants expressed their highest appreciation for the facilitators of the learning collaborative, who provided continuous technical assistance, resources, training, encouragement, and guidance in the implementation of PCRP. The participants expressed their gratitude and admiration for their professionalism, accessibility, and expertise in the field of PCRP implementation. They expressed their intention to continue seeking implementation support services from the collaborative facilitator team and/or participate in similar future initiatives.

Conclusions and Future Activities

The implementation of a complex recovery-oriented practice such as person-centered recovery planning (PCRP) requires attention to multiple aspects of the change process, including overall agency culture, stakeholder competencies in PCRP, and organizational business practices. Attention to all areas is necessary in order to get traction and to advance the practice of PCRP. This learning collaborative has been an opportunity to demonstrate how these factors come together and can demonstrate to the mental health field potential best practices for similar implementation programs.

Organizational readiness to change is critical to consider when bringing diverse agencies together for a learning collaborative. Other key components of a learning collaborative leading to successful implementation emerged from the evaluation of participant and facilitator discussions. These include:

- Regular and targeted technical assistance
- Ongoing communication with learning collaborative facilitators and staff
- Inclusion of direct support staff as well as people in recovery from the beginning in discussions/ implementation activities
- Presence and investment from the agency leadership
- Structured approach to organizing the learning collaborative activities
- Structured approach to tracking and reporting progress and success, i.e. monthly and year-end reports
- Communication of expectations in the learning collaborative application that agencies provide regular updates on and demonstrate commitment to implementation of PCRP
- PCRP certification or education/professional development credits linked to participation in similar initiatives
- Grouping with more similar agencies to allow for more tailored technical assistance

While more structured implementation activities and monthly reporting procedures were originally planned for the collaborative, the facilitators made a conscious decision to relax these expectations due to the significant disruption of the COVID-19 pandemic. It is likely that a more structured approach would have yielded deeper implementation of person-centered practices but this was not possible in the context of other agency pressures.

Conclusions and Future Activities (Continued)

For future learning collaboratives, we will consider more similar agency grouping to allow for more tailored technical assistance. This approach might allow for targeted support around priority issues and particular aspects of implementation (e.g. introducing PCRP to your agency, in-depth skills training, modifying your EHR/templates, capitalizing on your peer workforce in supporting PCRP, etc.).

All five of the learning collaborative agencies appear to have benefited by developing a clearer understanding of the nature and value of PCRP. The scope of changes that the agencies achieved on the ground as a result of this understanding varied significantly. Two out of the five agencies went further in changing their processes and implementing what they learned though training. They are putting in practice new person-centered treatment planning procedures and modifying the structure of their EHR tracking and documentation systems to accommodate these new procedures. The three other agencies have focused on disseminating the information to their internal teams and internal training to boost the staff's competency in PCRP.

These findings will inform the New England MHTTC's future efforts to organize multi-agency learning collaboratives.

Person-Centered Recovery Planning Resources

Person-Centered Recovery Planning (PCRP) Implementation Webinar Series—Part 1 and Part 2

Janis Tondora, PsyD. from Yale University's Program for Recovery and Community Health, and Dan Wartenberg, Psy.D, M.P.H., Director, Zero Suicide Project, Newport Mental Health reviewed the key indicators of PCRP from both a process and a documentation perspective.

This tool, *Recovery Roadmap: Tips for Recognizing Person-Centered Process* can help you to reflect on the extent to which your planning meetings/conversations reflect certain person-centered practices and content.

This tool, *Recovery Roadmap: Tips for Recognizing a Good Person-Centered Plan*, can help you to reflect on the extent to which your plan documentation reflects certain person-centered practices and content.

Reference

Institute of Medicine (IOM). (2001). *Crossing the quality chasm: A new health system for the 21st century*. National Academy Press.

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About the Mental Health Technology Transfer Network (MHTTC)

The purpose of the MHTTC Network is technology transfer—disseminating and implementing evidence-based practices for mental disorders into the field.

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the MHTTC Network includes 10 Regional Centers, a National American Indian and Alaska Native Center, a National Hispanic and Latino Center, and a Network Coordinating Office.

This collaborative network supports resource development and dissemination, training and technical assistance, and workforce development for the mental health field. We work with systems, organizations, and treatment practitioners involved in the delivery of mental health services to strengthen their capacity to deliver effective evidence-based practices to individuals.

MHTTC services cover the full continuum spanning mental illness prevention, treatment, and recovery support.

For more information, contact the MHTTC Network Office.

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