

NVMHI Response to “The Recovery Experience” OIG Report

August 2007

Updated December 2010

Senior Leadership Role

Goal: Create an environment through policies, systems, and modeling that leads to person-centered, recovery-based, practices throughout the facility.

Strategy 1:

Facilitate establishing unit level norms for communication processes that address staff behaviors that are consistent with recovery principles and addressing those that are not.

Final Outcome Measure:
Increase of 10% in Staff Satisfaction Survey Questions.

DUE DATE: July 2008

Baseline Measure (July 2007):
Employee Satisfaction Survey Question “*There is adequate communication between departments.*”-23%
Employees Satisfaction Survey Question “*I believe there is a spirit of cooperation at NVMHP*”-54%

Interim Measure (Jan. 2008):
Increase of 5% in Staff Satisfaction Survey Questions.

We routinely conduct staff satisfaction surveys in March of each year. In light of survey adjustments being recommended by our HPO team, we decided to stay on the routine schedule rather than report an interim measure. All clinical treatment teams had 4 sessions of a standardized team building training from 9/18/07-10/9/07. An average of 39 staff attended each session. Our HPO leadership team is currently providing individualized coaching for each treatment team. The team principles that were introduced in the training are being utilized to explore specific team

Responsible Party:
HPO Steering Team and ROCC Team; Unit Teams

		<p>based processes. This phase will be completed by 6/08.</p> <p>July 2008- Data from the March 2008 Staff Satisfaction Survey demonstrated a 9% satisfaction increase for Question “There is adequate communication between departments” (32%); however, there was a 1% decrease in staff satisfaction for Question “I believe that there is a spirit of cooperation at NVMHI” (53%). Coaching at the team level was completed June 30, 2008 and included sharing observations related to team interactions and communication. Since the staff satisfaction survey was conducted in March 2008 the scores do not reflect impact of the coaching. We will do our next measure with the Staff Satisfaction Survey scheduled for March 2009.</p> <p>Shared expectations for communication processes were established facility-wide, are posted in all treatment team rooms, and provided to each employee. The next phase of the plan to strengthen communication processes will involve working with staff of each Service Area.</p>	
<p><u>Strategy 2:</u> Use all opportunities to communicate expectation and celebrate evidence</p>	<p><u>Final Outcome Measures:</u> 1) 20% improvement on Consumer</p>	<p><u>Baseline Measures (July 2007):</u> 1) Consumer Interview, Q11E – 50%</p>	<p><u>Responsible Party:</u> Senior Leadership</p>

<p>that consumers are encouraged and supported to be involved in decision making, to exercise choice at all levels, and activities undertaken to promote wellness and recovery.</p>	<p>Interview, Q11E.</p> <p>2) 20% improvement on Consumer VRAI, Q5 & Q11.</p> <p><u>DUE DATE: July 2009</u></p>	<p>2) Consumer VRAI, Q5 – 41% (55) Consumer VRAI, Q11 – 71% (67)</p> <p><u>Interim Measure (July 2008):</u> 10% improvement on Consumer Interview, Q11E and Consumer VRAI, Q5 & Q11.</p> <p>Motivational Interviewing Workgroup and the RCSC created “My Recovery Plan” which is used to prepare individuals for their treatment planning meeting by guiding them through the creation of their own treatment plan. The process and packet was piloted on K and F units with selected patients to determine the effectiveness. The workgroup is now developing a plan for how to implement this process hospital wide.</p> <p>July 2008 Consumer Interview Q11E – 58% - 8% increase Consumer VRAI Q5: 64% - 23% increase Consumer VRAI Q11: 70% - 1 % decrease</p> <p><u>Final Outcome Measure (July 2009)</u> Consumer Interview Q11E: 77% (27% improvement from baseline) Consumer VRAI Q5: 68% (27% improvement from baseline) Consumer VRAI Q11: 80% (9% improvement from baseline)</p>	<p>Team</p>
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<p>Strategy 3: Utilize <i>Self Assessment and Growth Plan for Recovery Skills</i> (USPRA Webinar, 2007) to self rate recovery based behaviors and identify specific learning goals and strategies for upcoming performance cycle.</p>	<p><u>Final Outcome Measure:</u> Annual performance reviews for all staff will reflect learning goals based on <i>Self Assessment and Growth Plan for Recovery Skills</i> (USPRA Webinar, 2007) to increase behaviors consistent with recovery principles.</p> <p><u>DUE DATE:</u> Oct. 2009</p>	<p><u>Baseline Measure (July 2007):</u> Recovery-based learning goals do not exist for any positions at NVMHI.</p> <p><u>Interim Measure (Nov. 2007):</u> All clinical staff will complete a self assessment using identified tool and develop personal learning goals for upcoming performance cycle to increase behaviors consistent with recovery principles.</p> <p>100% of Clinical Staff completed self assessment tool by December 7, 2007 to identify personal learning goals to increase behaviors consistent with recovery principles.</p> <p><u>Interim Measure (Nov. 2008) :</u> All non-clinical staff will complete a self assessment using identified tool and develop personal learning goals for upcoming performance cycle to increase behaviors consistent with recovery principles.</p> <p><u>July 2008:</u> Non-clinical staff are in the process of selecting measures to be used for self-assessment for the upcoming performance review cycle in 2008. All clinical staff will once again do a self assessment this fall with annual evaluations.</p> <p><u>November 2008</u> – As part of the performance evaluation process, 100% of non-clinical staff completed a self</p>	<p><u>Responsible Party:</u> Director of Human Resources and All Department Heads</p>
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		<p>assessment and developed personal learning goals for the upcoming performance review cycle. All clinical staff completed self assessments during their annual evaluation.</p> <p>October 2009 – 100% of staff completed a self assessment and developed personal learning goals.</p>	
<p><u>Strategy 4:</u> Facilitate dialogue and decisions on the appropriate “person first” language to use within the hospital setting with consideration to each unique service area.</p>	<p><u>Final Outcome Measure:</u> Staff and consumers will understand rationale for and utilize specific “person first” designators.</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measures (July 2007):</u> Limited and inconsistent use of “person first” language throughout facility.</p> <p><u>Interim Measure (Feb. 2008):</u> Dialogues started on each service area regarding appropriate “person first” language to use within hospital setting.</p> <p>Focus groups with staff and current consumers on each service are scheduled during February 2008 to determine preferences for person-first language.</p> <p>July 2008 - Focus groups were held during the month of February 2008. The preferences for person-first language as determined by the participants was that their names be used when possible and when not possible (due to privacy issues) the term “individual” should be used.</p> <p><u>Final Outcome Measure (July 2009)</u></p>	<p><u>Responsible Party:</u> Senior Leadership Team with Clinical Department Heads</p>

		The preferences for person-first language as determined by the participants in focus groups were communicated to staff in individual department meetings. Education is also provided to new employees during their orientation.	
<p><u>Strategy 5:</u> Identify and align policies to assure that opportunities for choice and consumer self empowerment are maximized.</p>	<p><u>Final Outcome Measure:</u> 100% of designated policies are revised</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measures (July 2007):</u> Policies have not been systematically reviewed to assure opportunities for choice and self-empowerment.</p> <p><u>Interim Measures (Jan. 2008):</u> System for identifying policies needing revision will be developed and initial implementation started.</p> <p>A system for identifying policies needing revision was implemented. Once policies are identified, priority for revision will be established.</p> <p><u>Interim Measure (July 2008):</u> 50% of designated policies will have been reviewed to assure opportunities for choice and self-empowerment. Policy sponsor for all designated policies will document consideration of recovery principles in policy review.</p> <p>As of June 30, 2008 67% of identified policies have been aligned to assure that opportunities for choice and consumer self empowerment are maximized. A structure is in place</p>	<p><u>Responsible Party:</u> Senior Leadership Team with Chair of Policy Review Committee</p>

		<p>that requires inclusion of these principles any time any policy is reviewed/revised.</p> <p><u>Final Outcome Measure (July 2009)</u> 92% of NVMHI policies have been reviewed and/or revised to assure that person-first language and opportunities for choice and consumer self empowerment are maximized.</p>	
<p><u>Strategy 6:</u> Continue HPO work on culture change, structural, process and system alignment to create an environment that reflects commitment to recovery principles.</p>	<p><u>Final Outcome Measure:</u> 20% improvement in Staff Satisfaction Survey relative to shared goal within facility</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measures (July 2007):</u> Staff Satisfaction Survey, Q"<i>I feel part of a team working toward a shared goal</i>" – 58%</p> <p><u>Interim Measure (Jan. 2008):</u> Using HPO process, develop list of shared, facility values that support Mission and Vision.</p> <p>Through multiple small focus groups, involving all hospital staff and offered on different days/shifts, we identified the collective staff thinking about the most salient values. The HPO leadership group then ranked the most frequently emerging values. Five values were identified and celebrated during an ice cream social on all shifts. The values are: safety, respect, teamwork, optimism, and communication.</p> <p><u>Interim Measure (July 2008):</u> Develop a mechanism for integrating facility values into job expectations for all positions.</p>	<p><u>Responsible Party:</u> Senior Leadership Team with ROCC Steering Committee</p>

		<p>This has been completed. The HPO leadership group (ROCC) developed behavioral measures for each value which were incorporated into the Performance Expectations for all NVMHI staff for 2008.</p> <p><u>Final Outcome Measure (July 2009)</u> In the fall of 2008, ROCC was chartered by the Senior Management team to continue ongoing HPO processes. These activities have included treatment team, clinical service area and administrative team facilitation which focus on optimal team functioning. Another aspect of the ROCC charter was to conduct a pilot program for middle management training in HPO principles. Three sessions were presented which were well received by staff.</p> <p>In February 2009, the Clinical Department Heads began mentoring all treatment teams focusing on treatment planning processes.</p> <p>The most recent Staff Satisfaction (FY 09) survey demonstrated an 8% improvement over the baseline in staff satisfaction related to staff feeling like they are part of a team working towards a shared goal.</p>	
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<p><u>Strategy 7:</u> Continue developing the NVMHI Regional Community Support Center (RCSC) within the scope of financial resources.</p>	<p><u>Final Outcome Measure:</u> Community-based consultations and educational programs on practices that incorporate recovery principles when consumers are at risk for behavioral emergencies and trauma-informed services.</p> <p><u>DUE DATE: July 2010</u></p>	<p><u>Baseline Measures (July 2007):</u> No consultation requests</p> <p><u>Interim Measure (July 2008):</u></p> <ul style="list-style-type: none"> • Educational programs and consultations have already occurred. The first Annual Conference was held in May, 07. • Four consultations involving community based crisis care centers/staff have been conducted. • Leaders from a local private psychiatric hospital have visited NVMHI. • Training for Fairfax ADC deputies has been requested and a curriculum developed, with consumer/family involvement. Training scheduled for February 2008. • An Advisory Council with representation from all community stakeholders is in the process of being established. <p>July 2008 – The second annual Recovery Conference was held in May 2008. A total of 9 consultation requests, including both inpatient (private and public) and community settings were received and all were completed. The RCSC Director position was vacated in May 2008. The responsibilities are being shared between the Asst. CNE (former RSCS Director), the Director of Social Work</p>	<p><u>Responsible Party:</u> Facility Director with Director of RCSC.</p>
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		<p>and the Active Treatment Coordinator. Regional funding was approved to hire a Regional Peer Bridger.</p> <p><u>Final outcome measure (July 2010)</u> The RCSC has continued to provide consultation and community based conferences. In January 2009 the RCSC held a half day conference and a full day conference in June 2009. Both conferences focused on Trauma and Trauma Informed Care. The January conference had a turnout of approximately 130 attendees. The June 2009 conference had approximately 160 attendees. In June 2010, the Annual RCSC Conference highlighted best practices within the community. All highlighted programs were recovery based and trauma informed. Commissioner Stewart was in attendance and provided the keynote speech.</p> <p>The RCSC has continued to fund the Regional Peer Bridger.</p> <p>The RCSC partners with NVMHI and provides part of the Arlington CIS training on an ongoing basis.</p> <p>An advisory council which meets regularly was established with the goal to have representation from both providers and consumers/family member from all regions. While representation has fluctuated, there has been a consistent representation from 7 individuals (4 consumers and 3 providers).</p>	<p>Responsible Party: Chief Nurse Executive (former RSCS Director) & ACNE</p>
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Workforce Development

Goal: All staff will be trained on and utilize recovery-based principles in working with consumers who receive services at NVMHI.

Strategy 1:

Conduct two Grand Rounds that teach models for conducting large group meetings That provide a forum to effectively address community living concerns.

Final Outcome Measure:
Increase of 10% on related Patient Satisfaction and VRAI scores

DUE DATE: July 2009

Baseline Measure (July 2007):
VRAI Q13-44% (65)
Patient satisfaction on D/C Q4-80%

Interim Measure (Jan. 2008):
2 units pilot model

Sr. Mgmt monitoring during AM report has revealed that clinical staff have consistently held unit meetings 24/7 when events of concern have occurred. The Treatment Integration Group reviewed literature and discussed a model for large group meetings. Two Grand Round sessions are scheduled for February 2008 (2/13 & 2/27) to introduce principles for conducting large group meetings.

July 2008: Using learning from the two Grand Rounds, over the past few months the Service Areas initiated regular community meetings and as of July 2008 all units expanded to community meetings five days a week. Anecdotal response from individuals has been very positive.

Final Outcome Measure (July 2009)
All living units conduct routine community meetings providing a forum for addressing community living concerns.

Responsible Party:
Director of Human Resources and Training Coordinator

Clinical Integration Group

		VRAI Q13 = 80% (a 39% improvement from baseline) Individual satisfaction survey Q4 = 83% (a 3% improvement from baseline)	
<p><u>Strategy 2:</u> Expand initial and on-going training (i.e., NEO, NCEO, AUT) on recovery principles, including topics of: choice, consumer-run services, consumer advocacy and self-empowerment. Include persons in recovery as presenters.</p>	<p><u>Final Outcome Measure:</u> 20% improvement on Staff VRAI, Q6 & Q13.</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measures (July 2007):</u> Staff VRAI, Q6 – 63% Staff VRAI, Q13 – 84%</p> <p><u>Interim Measure (July 2008):</u> 10% improvement on Staff VRAI, Q6 & Q13.</p> <p>Effective 1/08 a segment on Recovery is now included in NEO. The New Clinical Employee Orientation Recovery course has been revised and expanded to include more information on consumer-run services, consumer advocacy and self-empowerment. AUT is scheduled to be revised in the fall of 2008.</p> <p>On August 4, 2008 representatives from the Virginia Office of Protection and Advocacy presented a session to individuals and staff on resources in the community and options for seeking support.</p> <p>May 2008- Staff VRAI Q6 = 85% a 22% increase Q13 = 89% a 5% increase</p> <p><u>Final Outcome Measure (July 2009)</u> Staff VRAI</p>	<p><u>Responsible Party:</u> Director of Human Resources, Training Coordinator and Active Treatment Coordinator</p>

		<p>Q6= 73% (a 10% improvement from baseline) Q13= 92% (an 8% improvement from baseline)</p>	
<p><u>Strategy 3:</u> Expand initial and on-going training (i.e., NEO, NCEO, AUT) on recovery-informed treatment planning process.</p>	<p><u>Final Outcome Measure:</u> 20% improvement on Tx. Team Observation Checklist, Q11 & Q12.</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measure (July 2007):</u> Observation Checklist, Q11 - 67% Observation Checklist, Q12 – 67%</p> <p><u>Interim Measure (July 2008):</u> 10% improvement on Tx. Team Observation Checklist, Q11 & Q12.</p> <p>Training on recovery-informed treatment planning process was provided to clinical staff (March & April '08) and has been incorporated into New Clinical Employee Orientation.</p> <p>July 2008-Treatment Team Observation Checklist Q11: 83% a 16% increase Q12: 100% a 33% increase</p> <p><u>Final Outcome Measure (July 2009)</u> Over the past FY NVMHI further refined the treatment planning forms and processes. Educational offerings were held for clinical staff on these processes, one specifically devoted to Person-centered treatment planning. In addition, team-based person-centered treatment planning sessions were conducted with each treatment team. The Clinical Department Heads began individual team mentoring in</p>	<p><u>Responsible Party:</u> Director of Human Resources, Training Coordinator and Director of Clinical Services Development</p>

		<p>these processes.</p> <p>Treatment Team Observation Checklist Q11: 77% - a 10% increase from baseline; Q12: 91% - a 24% increase from baseline.</p>	
<p><u>Strategy 4:</u> Refine structure for treatment team consultation for improving collaboration and partnerships when consumers present challenging behaviors.</p>	<p><u>Final Outcome Measure:</u> 10% improvement on Consumer VRAI, Q3, Q4 & Q5. <u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measure (July 2007):</u> Consumer VRAI, Q3 – 37% (67) Consumer VRAI, Q4 – 40 % (74) Consumer VRAI, Q5 – 41 % (55)</p> <p><u>Interim Measure (July 2008):</u> 5% improvement on Consumer VRAI, Q3, Q4 & Q5.</p> <p>In addition to Clinical Case Conferences and Prescription Team Meetings, Peer Case Consultations began in December. There have been 9 Peer Case Consultations held to date.</p> <p>A Peer Consultation can be used for resolving clinically relevant issues such as diagnostic clarification, treatment strategies and medication recommendations. The Peer Consultation group consists of members of various disciplines who review cases upon request of another team.</p> <p>New Treatment Planning forms and process are now in effect. Review and update of the “Partnership for Safety”</p>	<p><u>Responsible Party:</u> Clinical Department Heads led by Medical Director.</p>

		<p>was incorporated into the Treatment Planning and Threshold Review processes.</p> <p>July 2008 –Consumer VRAI: Q3: 74% - a 37% increase Q4: 68% - a 28% increase Q5: 64% - a 23% increase</p> <p><u>Final Outcome Measure (July 2009)</u> Consumer VRAI: Q3:83% - a 46% improvement from baseline Q4:80% - a 40% improvement from baseline Q5:68% - a 27% improvement from baseline</p>	
<p><u>Strategy 5:</u> Measure and improve staff knowledge of trauma-informed services, competency in motivation enhancing interventions, and assessment and treatment of co-occurring disorders.</p>	<p><u>Final Outcome Measure:</u> Evidence that concepts are integrated into treatment plans, when appropriate.</p> <p><u>DUE DATE: July 2010</u></p>	<p><u>Baseline Measure (July 2007):</u> No formal mechanisms in place to measure.</p> <p><u>Interim Measure (July 2008):</u> 90% of clinical staff attend at least one training event in each of these three areas annually.</p> <p>In October, we hired a Psychologist with specific expertise in Trauma Informed Services. He has begun consultations with all treatment teams and partnered with our Substance Abuse Counselor for program development.</p> <p>83% of clinical staff have attended at least one training event on trauma</p>	<p><u>Responsible Party:</u> Clinical Department Heads led by Director of Clinical Services Development.</p>

		<p>informed care, 81% of clinical staff have attended at least one training event on co-occurring disorders and 88% of clinical staff have attended at least one training event on motivation enhancing interventions and assessments. Training will continue to be offered on an ongoing basis and tracked in FY09 in these categories.</p> <p><u>July 2009 Update:</u> Training continued to be offered during FY '09 with 92% of clinical staff attending at least one training event on trauma informed care; 89% attending at least one training event on co-occurring disorders and 93% attending at least one training event on motivation enhancing interventions.</p> <p><u>Final Outcome Measure: July 2010</u> Staff continue to be educated on trauma informed care during new employee orientation and ongoing during annual update training.</p> <p>98% or more of individuals receiving services in inpatient mental health facilities have a history of trauma. NVMHI has therefore implemented a universal approach to providing trauma informed care by integrating trauma informed practices at a systems level. Trauma information is obtained at admission via multiple avenues. Over time, this information is enhanced through the partnering of individuals and healthcare workers.</p>	
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		<p>A Partnership for Safety is developed with each individual upon admission and reviewed and updated at each TRPR. The Partnership for Safety allows us to engage in ongoing dialog about trauma experiences and identify potential triggers and individual preferences which can be taken into consideration when an individual is in crisis and when seclusion or restraint is indicated. In addition, clinical best practices such as calming rooms, weighted blankets, and therapeutic groups designed to address the sequelae of trauma are available to all individuals.</p> <p>As a next phase to becoming more proficient in the provision of trauma informed care, NVMHI is currently developing mechanisms for enhancing the incorporation of individualized trauma-informed practices into treatment planning. Specifically, these mechanisms will link knowledge of trauma experiences with the development of specific treatment interventions to minimize retraumatization and enhance recovery.</p>	
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Treatment Planning
Goal: Consumers who receive services at NVMHI will be an integral part of the treatment planning process.

<u>Strategy 1:</u> Continue current Treatment Planning Workgroup project involving redesign of treatment planning forms and process to better integrate consumer input and influence on goals and	<u>Final Outcome Measure:</u> 90% adherence on relevant Treatment Quality monitors. <u>DUE DATE: July 2009</u>	<u>Baseline Measure (July 2007):</u> Treatment Planning forms and process have inconsistent consumer-directed content. Revisions being developed by Treatment Planning Workgroup.	<u>Responsible Party:</u> Treatment Planning Workgroup, Chaired by Director of Clinical Services
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treatment.		<p><u>Interim Measure (Jan. 2008):</u> Pilot completed of new Treatment Planning forms and process better integrating consumer input.</p> <p>Treatment planning forms have been redesigned and a second pilot completed on 1/22/08. Refinements to the process are being made and will be piloted for 3 months. There are significant technological challenges and we may be forced to go back to a paper and pencil system which detracts from a person centered process.</p> <p><u>Interim Measure (July 2008):</u> 75% adherence on relevant Treatment Quality monitors.</p> <p>Treatment Planning forms were redesigned to integrate consumer input. The revised process and forms were fully implemented by all treatment teams by 4/30/08.</p> <p>Quality Audit Treatment Planning - Q #10 - "Is there clear evidence of the patient's level of participation in the development of the treatment plan?" – FY '08 YTD average adherence is 89%</p> <p><u>Final Outcome Measure (July 2009)</u> Treatment Planning Quality Audit Q10: FY '09 average 92%.</p>	Development.
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<p><u>Strategy 2:</u> Develop and implement a structure to support client preparation prior to treatment planning meetings to support increased involvement in the process.</p>	<p><u>Final Outcome Measure:</u> 10% improvement on Consumer VRAI, Q3, Q4 & Q11.</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measure (July 2007):</u> Consumer VRAI, Q3 – 37% (67) Consumer VRAI, Q4 – 40% (74) Consumer VRAI, Q11 – 71% (67)</p> <p><u>Interim Measure (July 2008):</u> 5% improvement on Consumer VRAI, Q3, Q4 & Q11</p> <p>July 2008 Consumer VRAI Q3 = 74% -27% increase Q4 = 68% - a 28% increase Q11 = 70% - a 1% decrease</p> <p>Motivational Interviewing Workgroup and the RCSC created “My Recovery Plan” to prepare individuals for their treatment planning meeting by guiding them through the creation of their own treatment plan. The process and packet was piloted on K and F units with selected patients to determine the effectiveness. The workgroup is now developing a plan for how to implement this process hospital wide.</p> <p><u>Final Outcome Measure (July 2009)</u> Consumer VRAI Q3:83% - a 46% improvement from baseline Q4:80%- a 40% improvement from baseline Q11:80% - a 9% improvement from baseline</p>	<p><u>Responsible Party:</u> Treatment Planning Workgroup, Chaired by Director of Clinical Services Development.</p>
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<p>Strategy 3: Develop structure for the consumer and the treatment team to jointly evaluate treatment planning meetings.</p>	<p>Final Outcome Measure: 90% Patient Satisfaction Survey at D/C, Q2. <u>DUE DATE:</u> July 2010</p>	<p>Baseline Measure (July 2007): Patient Satisfaction Survey at D/C, Q2 – 80%. No formal mechanism for evaluating treatment planning meetings.</p> <p>Interim Measure (July 2008): Workgroup formed to develop mechanism for evaluating treatment planning meetings. First draft of evaluation tool developed and initial pilot started.</p> <p>The Revised Treatment Plan forms include an evaluation tool.</p> <p>Interim Measure (July, 2009) Full implementation of treatment planning forms used to document individual and staff assessments of the treatment planning process was initiated in March 2009.</p> <p>Individual Satisfaction Survey at Discharge Q2 = 88%</p> <p>Final Measure (July 2010) <i>Individual Satisfaction Survey at Discharge Q6 & Q12 = 86%</i></p>	<p>Responsible Party: Treatment Planning Workgroup, Chaired by Director of Clinical Services.</p>
<p>Strategy 4: Each service will identify actions that will support consistent treatment team attendance by nursing staff and others, including family members, CSB representatives and other community members, at treatment planning</p>	<p>Final Outcome Measure: 20% improvement on Treatment Team Observation Checklist, Q4, Q5, Q8. <u>DUE DATE:</u> July 2009</p>	<p>Baseline Measure (July 2007): Team Observation Checklist, Q4–100% Team Observation Checklist, Q5– 33% Team Observation Checklist, Q8– 67%.</p> <p>Interim Measure (July 2008):</p>	<p>Responsible Party: Clinical staff led by Nursing Unit Managers and Clinical Department Heads.</p>

		<p>10% improvement on Treatment Team Observation Checklist, Q4, Q5, Q8.</p> <p>TX planning meeting schedules were refined to support improved attendance by all, including direct care staff and schedules are clearly posted to assist with schedule planning by staff and individuals served.</p> <p>Physicians and Nursing Unit Managers led an effort on I Service to identify barriers to attendance and find resolutions. One identified barrier was room selections for treatment planning. They identified additional rooms to allow scheduling planning on the individual's home unit to support RN attendance. In addition, large, easy to read bulletin boards with treatment plan schedules were added on both I units. CSB staff has access to NVMHI Outlook Calendar for scheduled CTP and TPR meetings to support their planning and attendance. In addition, the team Social Worker notifies the CSB staff of meetings at least 24 hours in advance.</p> <p>There was a 44% increase in CSB attendance (overall average) in FY '08.</p> <p>July 2008 Treatment Team Observations: Q4: 100% Q5: 66% - a 33% increase Q8: 100% - a 33% increase</p> <p><u>Final Outcome Measure (July 2009)</u></p>	<p>CSB Executive Directors</p>
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		Treatment Team Observations: Q4: 100% - an RN was present Q5: 82% - a 49% increase from baseline Q8: 86% - a 19% increase from baseline	
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Design of the Clinical Record
Goal: The clinical record will reflect the use of person-centered and recovery-based principles, be organized to facilitate ready access to information, and promote efficient and effective documentation.

<p><u>Strategy 1:</u> Implement guidelines for documentation across the facility that support “person first” language and recovery principles.</p>	<p><u>Final Outcome Measure:</u> 20% improvement on Record Review, Q13.</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measure (July 2007):</u> Record Review, Q13 – 43%</p> <p><u>Interim Measure (Jan. 2008):</u> Complete evaluation of existing documentation templates for support of “person first” language and recovery principles.</p> <p>The process for identifying and evaluating templates for person first language is in progress and will be completed in March 2008. Revisions will be underway once the preference for person first language is determined.</p> <p><u>Interim Measure (July 2008):</u> Develop guidelines for using “person first” language in all documentation. 10% improvement on Record Review, Q13.</p> <p>July 2008 – Focus groups with consumers were held to determine a consensus of their preference for “person-first” language. Those involved in the focus groups determined a preference of being referred to by either their name or the word</p>	<p><u>Responsible Party:</u> Clinical Department Heads</p>
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		<p>“individual”. The process for identifying and evaluating documentation templates for “person first” language was completed. The use of “person-first” language is included in New Clinical Employee Orientation. The development of guidelines for using “person-first” language is still in progress as is revision of the Documentation Policy to provide direction for the use of “person-first” language. Education of staff during New Employee Orientation and Annual Update Training will commence when the guidelines are fully developed. Ongoing supervision and department meetings will be used to reinforce the use of this language.</p> <p><u>Final Outcome Measure(July 2009)</u> The medical records of individuals served at NVMHI can be generally characterized as using person-first language that is non-stigmatizing, non-labeling, and not directive. There is evidence that there continues to be some use of the term “patient” in the record (mostly related to ID or progress notes); however the treatment plans and assessments generally refer to the individual by his/her name or the term “individual”.</p>	
<p><u>Strategy 2:</u> Continue work started by the Treatment Planning Workgroup to provide a structure for integrating motivation-enhancing interventions and Stages of Change into treatment plans.</p>	<p><u>Final Outcome Measure:</u> 1) 10% improvement on Treatment Team Observation Checklist, Q11 & Q12.</p> <p>.</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measure (July 2007):</u> 1) Team Observation Checklist, Q11- 67% Team Observation Checklist, Q12 – 67%</p> <p><u>Interim Measure (July 2008):</u> 1) 10% improvement on Treatment Team Observation Checklist, Q11 & Q12.</p> <p>New treatment plans that integrate Stages</p>	<p><u>Responsible Party:</u> Treatment Planning Workgroup, Chaired by Director of Clinical Services Development</p> <p>Implementation by Clinical</p>

		<p>of change and motivation enhancing goals started on 3/31/08. Training for clinical staff was held in March and April 2008.</p> <p>July 2008 -Team Observation Checklist: Q 11: 83% - a 16% increase Q 12: 100% - a 33% increase</p> <p><u>Final Outcome Measure (July 2009)</u> Treatment Team Observations: Q11: 76% - a 9% increase from baseline Q12: 91% - a 24% increase from baseline</p>	Department Heads.
<p><u>Strategy 3:</u> CO evaluate composition, structure and process for designing an EHR to assure integration of recovery principles in a manner that facilitates efficient and effective documentation.</p>	<p><u>Final Outcome Measure:</u> Facility workgroup participants report being empowered to think innovatively about a record design that will support recovery-based treatment and meet relevant external review requirements.</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measure (July 2007):</u> CO to establish</p> <p><u>Interim Measure (July 2008):</u> CO to establish</p> <p><u>Final Outcome Measure (July 2009)</u> CO to establish</p>	<p><u>Responsible Party:</u> CO project Team Leader</p>
<p><u>Consumer Activities and Opportunities</u> Goal: Activities and opportunities provided will increasingly reflect and incorporate recovery-based principles.</p>			
<p><u>Strategy 1:</u> Continue full consumer involvement in establishing Calming Rooms and Calming Kits on each unit.</p>	<p><u>Final Outcome Measure:</u> 10% improvement on Consumer VRAI, Q5.</p> <p><u>DUE DATE: July 2008</u></p>	<p><u>Baseline Measure (July 2007):</u> Consumer VRAI, Q5 – 41% (55)</p> <p><u>Interim Measure (Jan. 2008):</u> 5% improvement on Consumer VRAI, Q5.</p> <p>Consumers were involved in the planning of the calming rooms, including choosing the location of the rooms, naming the rooms (e.g. one service calls their rooms</p>	<p><u>Responsible Party:</u> Clinical staff led by Active Treatment Coordinator.</p>

		<p>the “Oasis Room”), and selecting items for use in the rooms. They also planned and painted the murals on the room walls.</p> <p>The Calming Rooms on I1 and I2 were opened in mid-July, 2007. The F1 and F2 Oasis rooms were opened on October 17, 2007 and the K unit Calming Room was opened on October 18, 2007. All units have been provided with extra supplies for calming kits and feedback is being solicited on the most popular items used in the calming rooms to evaluate kits. Relaxation CDs can be signed out by individuals. Some relaxation items have been used by people going on pass or ordered for discharge. In addition, clients who are signed up for the “Coping through the Senses Group” are making their own individualized sensory kits.</p> <p>Consumer VRAI is scheduled to be completed 2/08.</p> <p>July 2008 -There is ongoing data collection regarding calming room use and correlation with aggression and seclusion and restraint. In addition, a celebration is being held on each unit on the anniversary of opening the calming room. The first one-year celebrations were held In August 2008. Also, a yearly review of items available in calming rooms and which ones are most commonly used/preferred by patients is made along with ordering novel items in order to continually improving services</p>	
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		<p>provided.</p> <p>July 2008 Consumer VRAI Q5 = 64% a 23% increase</p>	
<p><u>Strategy 2:</u> Continue full consumer involvement in creating Stages of Change murals.</p>	<p><u>Final Outcome Measure:</u> Completion of murals</p> <p><u>DUE DATE:</u> July 2008</p>	<p><u>Baseline Measure (July 2007):</u> Programming focused on Stages of Change beginning to be offered.</p> <p><u>Interim Measure (Jan. 2008):</u> 25% increase in available programming on Stages of Change. Beginning development of Stages of Change murals.</p> <p>Murals were completed June 2007 with consumer participation; Posters ordered and installed in team rooms in September 2007.</p> <p>2 stages of change groups added Spring 2007. VRAI scheduled to be completed 2/08 (200% increase)</p> <p>July 2008-Two groups focused on Stages of Change are offered per cycle. An average of 7-10 individuals have been attending these groups – 200% increase</p>	<p><u>Responsible Party:</u> Clinical staff led by Director of PSR.</p>
<p><u>Strategy 3:</u> Develop resource teams, including consumers, to establish and maintain Recovery Kiosks on each unit to distribute recovery and leisure literature/resources.</p>	<p><u>Final Outcome Measure:</u> 50% improvement on Hospital Unit Observation Checklist, Q6 & Q14.</p> <p><u>DUE DATE:</u> July 2008</p>	<p><u>Baseline Measure (July 2007):</u> Unit Observation Checklist, Q6 - 80% Unit Observation Checklist, Q14 – 0%</p> <p><u>Interim Measure (Jan. 2008):</u> Resource teams established on each unit with initial ideas and materials for Recovery Kiosks identified.</p>	<p><u>Responsible Party:</u> Clinical staff led by Active Treatment Coordinator and Nursing Unit Managers.</p>

		<p>Nursing Unit Managers have developed staff and patient teams on each unit. Teams are identifying space on each unit for their recovery corner, equipment (shelves, wall slots, etc.) needed for the space, how to decorate and developing a system for keeping materials stocked. Additional recovery literature and resources are on order and/or being downloaded from various sites to stock each unit.</p> <p>July 2008 – Completion of the hiring process for the Peer Bridger position should be completed in the next few weeks. This consumer will run a group on all three services (F, I & K) that will incorporate resources of the Recovery Center and will be a member of the Resource Team. The group will begin with the rotation that starts in October 2008.</p> <p>Recovery Corners have been set up and maintained on all five units since April 2008. Recovery materials include pamphlets, magazines, resource lists, videos and posters. A question has just been added to the current Unit Observation Checklist to audit that resources are being maintained in the Recovery Corner and that there is a variety of specific recovery materials maintained. Implementation of this revised Unit Checklist will begin with the August 2008 audit.</p> <p>In addition to the Recovery Corner the following have been implemented to incorporate the use of recovery materials</p>	
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		and resources: Chaplain Corner Scrapbooking Resources group	
<p><u>Strategy 4:</u> Establish programming to teach consumers about their role in helping relationships and treatment partnerships for self empowerment and advocacy.</p>	<p><u>Final Outcome Measure:</u> 50% increase in available programming to teach consumers about their role in helping relationships and treatment partnerships for self empowerment and advocacy beginning to be offered.</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measure (July 2007):</u> Programming to teach consumers about their role in helping relationships and treatment partnerships for self empowerment and advocacy beginning to be offered.</p> <p><u>Interim Measure (July 2008):</u> 25% increase in available programming to teach consumers about their role in helping relationships and treatment partnerships for self empowerment and advocacy beginning to be offered.</p> <p>A group of consumers are working with staff to develop a template for recovery resource/journal for people to use while in treatment her and as a part of discharge planning. Individual consumers participated in coaching sessions 1:1 and made oral and written presentations at the Budget Hearings held in the region in January. NAMI Peer to Peer groups have begun and are well received.</p> <p>July 2008 – WRAP group completed a full cycle of programming between February and April 2008. Consumer-run programming lost funding and NVMHI is currently exploring other options. A Peer Bridger position has been funded by the RCSC – and this position will run a group on all three services (F, I & K) that will incorporate resources of the Recovery</p>	<p><u>Responsible Party:</u> Clinical staff led by Active Treatment Coordinator.</p>

		<p>Center. The group will begin with the rotation that starts in October 2008.</p> <p>Current programming has been reviewed and has confirmed that we have a variety of groups that include materials and opportunities to improve helping relationships and treatment partnerships for self-empowerment and advocacy. Some groups that we currently offer that focus on these skills include: family dynamics, DBT skills, mindset for recovery art therapy, living in recovery, interpersonal social skills, creating hope: trauma group, recovery management, hope happens, coping with trauma art therapy, and new beginnings (women only).</p> <p>A master WRAP trainer was providing groups through LMEC by a grant. The grant was not renewed. NVMHI is looking for a WRAP facilitator, but although contacts have been developed a WRAP facilitator has not been found. The RCSC has funded a Regional Peer Bridger Specialist who is WRAP trained and will provide a WRAP group at NVMHI when the hiring process is complete. In addition, LMEC is looking to fund another WRAP facilitator through grants that would provide a WRAP group here at NVMHI.</p> <p><u>Final Outcome Measure (July 2009)</u> NVMHI currently has a full-time Peer Bridger Specialist working with individuals and staff to empower those we</p>	
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		<p>serve to play an active part in their treatment. We have maintained a variety of programs that include materials and opportunities to improve helping relationships and treatment partnerships for self-empowerment and advocacy. Some groups include: WRAP, Ask the Peers, Building relationships, Life's Journey, Progress Not Perfection: A dual recovery group, Jump Start (your recovery), Getting it Together (entirely peer-created and peer-led group) etc. Many of these groups are peer-led or co-led. Individuals have participated in additional conferences and groups outside the facility including DTR Facilitator Training(8 peers and 2 staff attended the Double Trouble in Recovery facilitator training), Intentional Peer Support Training (12 peers attended this 4-hour training sponsored by the Ida Mae Campbell Foundation), Certified Peer Specialist Training, Alexandria Alcohol Awareness Conference (6 peers attended), VOCAL conference (3 peers attended), WRAP/DBT at the Arlington County Detention facility (peers provided groups to incarcerated peers in Arlington), etc.</p>	
<p><u>Strategy 5:</u> Develop and utilize resource list for staff to initiate outings that build connections with communities.</p>	<p><u>Final Outcome Measure:</u> 5% improvement in Consumer VRAI, Q8. <u>DUE DATE:</u> July 2009</p>	<p><u>Baseline Measure (July 2007):</u> Consumer VRAI, Q8 –43% (83) <u>Interim Measure (July 2008):</u> Current score maintained at plus or minus 5% Consumer VRAI, Q8. A resource list has been developed.</p>	<p><u>Responsible Party:</u> Clinical staff led by Active Treatment Coordinator</p>

		<p>Community outings to build community connections are done several times a week. A Resource list was developed and has been in use since December 2007 select recovery-oriented outings which occur on an average of 3 times/week. Individuals have attended programs outside in the community such as Agape (92 individuals; 19 outings; average # individuals/outing – 5); LMEC (73 individuals; 16 outings; average # individuals/outing – 5; Prince William Drop-in Center (96 individuals; 17 outings; average # individuals/outing – 6). In addition, 4 individuals attended the Recovery Conference May 30, 2008.</p> <p>Consumer VRAI: Q8 = 62% a 19% increase</p> <p><u>Final Outcome Measure July 2009-</u> Individuals continue to attend programs outside in the community such as Agape LMEC Prince William Drop-in Center, Woodbridge Drop-In Center, and Seven Corners WRAP and a variety of external conferences and workshops. (see Strategy 4)</p> <p>Consumer VRAI: Q8 – 78% - a 35% improvement from baseline</p>	
<p><u>Strategy 6:</u> Evaluate and modify mechanisms for consumer input and evaluation of existing groups by individual group and by overall centralized programming.</p>	<p><u>Final Outcome Measure:</u> 1) 10% improvement on Consumer Interview, Q11F.</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measure (July 2007):</u> 1) Consumer Interview, Q11F – 50% (65)</p> <p><u>Interim Measure (July 2008):</u> 1) 5% improvement on Consumer Interview, Q11F.</p>	<p><u>Responsible Party:</u> Clinical staff led by Active Treatment Coordinator</p>

		<p>July 2008 - Development of group evaluations started as well as focus groups to solicit individuals' opinions about current group offerings. 31 evaluations received from individuals at the conclusion of the most recent treatment cycle. Results of the surveys and focus groups were shared with clinical staff to be included in planning programming for the next treatment cycle. Beginning with the current cycle, individual group evaluations will be completed for each group as well as for the whole treatment cycle.</p> <p>Consumer Interview Q11F- 58% an 8% increase</p> <p><u>Final Outcome Measure (July 2009)</u> Individual Satisfaction survey: "I had a choice of treatment options" – 71% - a 21% improvement from baseline</p>	
<p><u>Strategy 7:</u> Develop structure and implement programs that include consumer co-leadership and a consumer mentorship program.</p>	<p><u>Final Outcome Measure:</u> 1) 20% of programs offered will include a consumer co-leadership component.</p> <p><u>DUE DATE: July 2010</u></p>	<p><u>Baseline Measure (July 2007):</u> 1) No formal mechanism to support consumer co-leadership.</p> <p><u>Interim Measure (July 2008):</u> 1) Programs to include a consumer co-leadership component will be identified/developed.</p> <p>The Clinical Leadership Council Programming Subgroup continues working on formalizing a structure to support consumer co-leadership and</p>	<p><u>Responsible Party:</u> Clinical staff led by Active Treatment Coordinator.</p>

		<p>mentorship. Currently there are several programs that are either co-led by individuals or are completely consumer-run. Snack & Chat and Social Hour are run by consumers. Programs that are co-led include a weekly Wrap-up group, certain parts of the Market prep group and some community meetings.</p> <p><u>Final Outcome Measure (July 2010)</u> Consumer co-leadership or mentorship programming continues to be a principal of recovery which is supported by NVMHI. A strong component of this is the Regional Peer Bridger Specialist position which is sponsored by NVMHI in conjunction with the RCSC. Groups are also led by individuals from the community and by peers from within the facility. 13% of the overall groups offered at NVMHI are either co-led or peer led. On the Intermediate and Community Reintegration services, 16% of groups are led by peers, and on the Community Re-engagement Service alone, 4% of groups are peer led. NVMHI has become a recognized leader in peer-facilitated treatment throughout the state and individuals involved in peer-led programming have been asked to speak at conferences to provide others with knowledge and inspiration related to this endeavor. Journaling, employment support, computer skills, wellness, sign language, and 12 step programs are examples of peer led or mentored offerings. These offerings change with each 8-week cycle depending upon needs</p>	<p>Responsible Party Clinical staff led by PSR Director</p>
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		and interests of individuals and specific knowledge and skills of peer leaders. Regular community meetings and daily current event groups on the intermediate and recovery units are routinely peer led.	
<p><u>Strategy 8:</u> Provide, observe and support nursing staff with skills to use unstructured time in living units as an opportunity for increasing communal living skills and recovery activities.</p>	<p><u>Final Outcome Measure:</u> 1) 90% adherence to established criterion for using unstructured time as an opportunity for increasing communal living skills and recovery activities.</p> <p>2) 85% Patient Satisfaction at D/C, Q3</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measure (July 2007):</u> 1) No formal mechanism to provide and support nursing staff skills to use unstructured time as an opportunity for increasing communal living skills and recovery activities.</p> <p>2) Patient Satisfaction at D/C, Q3 – 80%</p> <p><u>Interim Measure (Jan. 2008):</u> 1) Formal mechanism established to teach nursing staff skills for using unstructured time as an opportunity for increasing communal living skills/ recovery activities.</p> <p>Five education modules have been developed and the first education module was initiated in January and is in progress. Observation criteria have been developed. The process for completing observations is being finalized.</p> <p><u>Interim Measure (July 2008):</u> 1) At least 50% adherence to established criterion for using unstructured time as an opportunity for increasing communal living skills/ recovery activities. 2) Maintain at +- 5% Patient Satisfaction at D/C, Q3</p> <p>July 2008 - Four trainings were held</p>	<p><u>Responsible Party:</u> Nursing Staff Development department led by Chief Nurse Executive.</p>

		<p>between January and June, 2008 for all nursing staff to support skill development. These skills are now being used in the units to help staff prepare individuals' transition into the community. Monthly unit observations are completed to monitor the success of training and skill building. Social Work and Nursing worked together to develop a resource book which provides information about each type of living situation and the type of skills individuals need to make a successful transition there.. The resource book was incorporated in staff training and is available on the units. A review of the use of Interpretation Services used by NVMHI over a 90 day period of time resulted in the identification of the 4 most common languages spoken by individuals admitted to NVMHI (English, Spanish, Korean and Vietnamese). NVMHI is currently translating our Patient Satisfaction surveys into these languages so that we can obtain more information from these individuals.</p> <p>The staff training completed at the end of May 2008 so the possible impact is not reflected in patient satisfaction surveys included in this report. Anticipate observing a positive impact from the training within 6 months.</p> <p>Most current results from patient satisfaction survey Q3 = 76% (3% decrease). April – June 2008 – Established Unit Observation criteria were met 93%-95% in all areas.</p>	
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		<p><u>Final Outcome Measure (July 2009)</u></p> <p>Unit Observations FY '09 = all established criteria met 94-99%</p> <p>Satisfaction at Discharge surveys demonstrated an average of 80% for Q3.</p>	
<p><u>Strategy 9:</u> Increase services provided by consumer-run agencies, i.e. LMEC, DBSA, NAMI-NoVa.</p>	<p><u>Final Outcome Measure:</u> 20% increase in number of consumers involved in consumer-run services and programs.</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measure (July 2007):</u> Number of consumers per month involved in at least one of the consumer-run programs offered at NVMHI - 26.</p> <p><u>Interim Measure (July 2008):</u> 5% increase in number of consumers involved in consumer-run services and programs.</p> <p>Over the past two treatment cycles a total of 77 individuals attended at least one of the available consumer-run groups offered at NVMHI. This represents an increase of 66 %.</p> <p><u>Final Outcome Measure (July 2009)</u> There is an average of 7 consumer-run programs offered in-house at NVMHI per cycle. Between January 1 and June 30, 2009 an average of 38 individuals/month attended at least one of the available consumer-run groups offered at NVMHI. The number of participants has remained fairly consistent from month-to-month (range 32-42). In addition, individuals served at NVMHI have had the opportunity to attend 5 consumer-run groups outside the facility.</p>	<p><u>Responsible Party:</u> Active Treatment Coordinator</p>

<p><u>Strategy 10:</u> Increase (pre) vocational, vocational, and volunteer service opportunities offered by community-based agencies, i.e. LMEC, PRS, Inc. and DRS.</p>	<p><u>Final Outcome Measure:</u> 15% increase in number of consumers involved in volunteer and paid employment in the community.</p> <p><u>DUE DATE:</u> July 2009</p>	<p><u>Baseline Measure (July 2007):</u> Number of consumers involved in volunteer and paid employment in the community (snapshot) – five</p> <p><u>Interim Measure (July 2008):</u> 10% increase in number of consumers involved in volunteer and paid employment in the community.</p> <p>A total of 12 individuals are involved in volunteer (10) and paid (2) employment in the community. Several individuals who were working in the community have recently been discharged.</p> <p><u>Final Outcome Measure (July 2009)</u> As of June 2009, a total of 45 individuals served at NVMHI were involved in volunteer and/or paid employment in the community.</p>	<p><u>Responsible Party:</u> Active Treatment Coordinator</p>
<p><u>Strategy 11:</u> Expand consumer involvement in committees, planning initiatives, and evaluation activities throughout the facility.</p>	<p><u>Final Outcome Measure:</u> Workgroup, Planning and evaluation activities that are reported through MEC will address consumer involvement.</p> <p><u>DUE DATE:</u> July 2009</p>	<p><u>Baseline Measure (July 2007):</u> Sporadic involvement of consumers in facility-wide workgroups, committees, planning initiatives and evaluation activities.</p> <p><u>Interim Measure (July 2008):</u> Structure will be established for consumer involvement in planning and evaluation activities.</p> <p>Consumer involvement in committees, planning initiatives and evaluation activities has expanded. There is currently a consumer and a family</p>	<p><u>Responsible Party:</u> Senior Leadership Team</p>

		<p>member involved in the Clinical Leadership Council (CLC) and 5 consumers are involved with the NVMHI Advisory Council. In August, 2008, the Programming Subcommittee of the CLC will have a consumer representative. A consumer-initiated suggestion has been adopted by the Employee Recognition Committee. The suggestion was for a process for individuals to participate in the “Caught-Ya” program – a way for them to acknowledge individual staff members who have positively impacted their care and recovery at NVMHI.</p> <p><u>Final Outcome Measure (July 2009)</u> NVMHI is currently recruiting to replace 2 consumers on the Clinical Leadership Council. There is currently 1 family member serving on the Clinical Leadership Council, 5 consumers on the Advisory Council and 5 consumers on the Recovery Support Committee.</p>	
<p><u>Relationship to the Community</u> Goal: Facility will continue to work closely with the community to promote integrated service continuum of recovery based services</p>			
<p><u>Strategy 1:</u> Work with members of Regional Recovery Workgroup to increase the number of WRAP trainers available to NVMHI consumers.</p>	<p><u>Final Outcome Measure:</u> WRAP sessions are consistently scheduled and provided on-site for NVMHI consumers as a part of regular programming.</p> <p><u>DUE DATE: July 2008</u></p>	<p><u>Baseline Measure (July 2007):</u> One WRAP trainer currently in area. WRAP sessions provided on-site for NVMHI consumers approximately 50% of calendar year.</p> <p><u>Interim Measure (Jan. 2008):</u> Additional consumers in the area trained as WRAP facilitators, who begin discussions with NVMHI to increase</p>	<p><u>Responsible Party:</u> Active Treatment Coordinator</p>

		<p>WRAP sessions provided on-site to NVMHI consumers.</p> <p>A WRAP Master Facilitator was hired as a contract employee through LMEC (consumer run organization) and is currently training an additional facilitator. Region- wide WRAP Training in Region II will begin March 3–7, 2008.</p> <p>WRAP groups were resumed @ the Institute on 1/22/2008</p> <p>July 2008 - Funding for WRAP services has been lost. The RCSC funded a Regional Peer Bridger Specialist to begin at NVMHI in August 2008. This specialist is a person who establishes relationships with individuals who currently reside in the NVMHI. The RPBS is also a WRAP Facilitator and will be leading a WRAP group for active treatment cycles. (I think this needs to move up closer to top because it addresses the initiative) Through a peer support relationship and mentoring, the RPBS assists these individuals in their transition back to the community. The RPBS is intended to serve those individuals who are being discharged from NVMHI, have an interest in employment, are committed to recovery, in need of peer support and volunteer to participate. The RPBS is matched with individuals who have been identified by facility or CSB discharge planner staff.</p>	
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		<p>A master WRAP trainer was providing groups through LMEC by a grant which was not renewed. NVMHI is looking for a WRAP facilitator, but although contacts have been made a WRAP facilitator has not been found. The RCSC has funded a Regional Peer Bridger Specialist that will provide a WRAP group at NVMHI when the hiring process is complete. In addition, LMEC is looking to fund another WRAP facilitator through grants that would provide a WRAP group here at NVMHI</p>	
<p>Strategy 2: Collaborate with CSB's regarding interface processes to support consumers' return to community at the earliest possible time and to a living place of choice.</p>	<p><u>Final Outcome Measure:</u> 1) 50% improvement on Tx. Team Observation Checklist, Q5. 2) 20% improvement on Consumer VRAI, Q11. <u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measure (July 2007):</u> 1) Team Observation Checklist, Q5 - 33% 2) Consumer VRAI, Q11 –71% (67) 3) Content of PTM meetings reflect variability in community readiness to facilitate patient choice</p> <p><u>Interim Measure (Jan. 2008):</u> 1) 25% improvement on Tx. Team Observation Checklist, Q5. 2) NVMHI will host regional leadership meeting to dialogue about recovery informed discharge planning and examine the degree to which current facility and community processes and attitudes are aligned with recovery informed thinking.</p> <p>On 10/18/2007, 48 NVMHI and CSB staff attended a successful regional meeting that was initiated and hosted by NVMHI. The goal was to work collaboratively with discharge planners, after care coordinators, and other CSB personnel to</p>	<p>Responsible Party: Facility director and CSB Executive Directors</p>

		<p>discuss discharge challenges. The Regional Project Manager and NVMHI Director of Social Work planned the four hour long “NVMHI Discharge Summit of the Minds”, with the active support and assistance of Russell Payne. Four facilitated focus groups were provided with relevant literature describing best practices in advance of the meeting and were asked to address the following issues:</p> <ul style="list-style-type: none"> • Bed usage/Transfers/Data; • Discharge Resources and Recovery Oriented Approaches; • Readmissions/Risk Aversion and Management in the Community and • Discharge Protocols/Procedures/System Demands. <p>Each group was asked to make a statement and description of the problem/barrier, identify contributing factors and service gaps, identify past or existing efforts and resources to address the problem, identify other systems that influence the process, recommend local or regional approaches with supporting rationale.</p> <p>Recommendations are under review by the CSB Execs and NVMHI Director.</p> <p>July 2008 – Follow-up from Discharge Summit:</p> <ul style="list-style-type: none"> • Improved communication between CSBs and NVMHI – several have been implemented including improved notification of CTPs and 	
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		<p>TPRs, more efficient processes for admissions from LIPOS beds, pursuit of better technology to enhance regional bed management communication (statewide committee formed to address this), team building activities between NVMHI and CSB staff,</p> <ul style="list-style-type: none"> • Discussion with ethics consultant on ethical issues around discharges and a planned Grand Rounds in October 2008 on Discharge Planning and Medical Complications • Implementation of immediate PTM or Clinical Case Conference for individuals being readmitted 2 times within 30 days • Financial considerations such as the use of RDAP funding <p>Team observation checklist- July 2008 Q5 71% - a 38% increase.</p> <p><u>Final Outcome Measure (July 2009)</u></p> <p>Treatment Team Observations: Q5: 82% - a 49% increase Consumer VRAI: Q11: 80% - a 9% improvement from baseline</p>	
<p><u>Strategy 3:</u> Increase relationships with community-based, consumer-run programs and services, i.e. LMEC, DBSA, NAMI-NoVa.</p>	<p><u>Final Outcome Measure:</u> 20% increase in number of consumers involved in consumer-run services and programs.</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measure (July 2007):</u> Number of consumers per month involved in at least one of the consumer-run programs offered at NVMHI - 26.</p> <p><u>Interim Measure (July 2008):</u> 10% increase in number of consumers</p>	<p><u>Responsible Party:</u> Active Treatment Coordinator</p>

		<p>involved in consumer-run services and programs.</p> <p>July 2008 – A Community Resource Book was completed and provided to all NVMHI Social Workers and Nursing Staff Development staff to incorporate with educating staff on establishing links to community supports and group homes. Consumers are now involved several times a week in outings to places such as LMEC, Agape, Prince William Drop-In Center with plans to expand the options for outings.</p> <p>Data of individuals participating in outings: Agape (92 individuals; 19 outings; average # individuals/outing – 5); LMEC (73 individuals; 16 outings; average # individuals/outing – 5; Prince William Drop-in Center (96 individuals; 17 outings; average # individuals/outing – 6) and 4 individuals attended the Recovery Conference on May 30, 2008.</p> <p>Consumers are also attending six on-site consumer - run groups.</p> <p>Over the past two treatment cycles a total of 77 individuals attended at least one of the available consumer-run groups. These include: – 6 on-site groups led by LMEC: 3 Employment Support Groups - (total attendance between February and June '08 = 124) and 3 Computer Skills Groups(total attendance between February and June '08 = 304)</p>	
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		<p><u>Final Outcome Measure (July 2009)</u> There is an average of 7 consumer-run programs offered in-house at NVMHI per cycle. Between January 1 and June 30, 2009 an average of 38 individuals/month attended at least one of the available consumer-run groups offered at NVMHI. The number of participants has remained fairly consistent from month-to-month (range 32-42). In addition, individuals served at NVMHI have had the opportunity to attend an average of 6 consumer-run groups outside the facility.</p>	
<p><u>Strategy 4:</u> Establish links with area group homes to develop peer support/ mentoring programs for consumers transitioning towards discharge.</p>	<p><u>Final Outcome Measure:</u> Decrease in 30 day re-admission rate for consumers discharged to area group homes.</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measure (July 2007):</u> No systematic plan for transitioning consumers who are being discharged to area group homes. Plan for transitioning inconsistent and varies per consumer and CSB.</p> <p><u>Interim Measure (July 2008):</u> Links established to enable initial discussions with area group homes focused on identifying common areas of difficulty that may lead to re-admission for NVMHI consumers.</p> <p>NVMHI is working through the HPRII Regional Office to establish collaborative processes that will include peers, consumers to aid in discharge transitions to group homes. In addition, the NVMHI Peer Bridger has accompanied individuals who have potential transition challenges on visits to group homes. The Peer Bridger also provided resource lists to</p>	<p><u>Responsible Party:</u> Director of Social Work and Utilization Manager</p>

		<p>group homes to help link them to access volunteer resources for help with specific populations with identified challenges.</p> <p><u>Interim Measure (Jan. 2009)</u> Initial implementation of peer support/mentoring programs at identified area group homes to support successful transitions.</p> <p>January 2009: NVMHI continues to partner with our region in pursuing avenues to minimize the use of the most restrictive setting (i.e., hospitalization) for consumers in need of mental health interventions.</p> <p>The Regional Peer Bridger Specialist is actively involved in “bridging” individuals back into the community including transitions to area group homes.</p> <p>A Peer Support handout was developed and is provided to individuals prior to discharge and/or during community reintegration passes. This document identifies peer support resources (Wellness or Drop-in centers) within the community that are consumer-founded and consumer-operated and open to all persons over the age of 18. It also includes resources for information on recovery. NVMHI actively encourages, promotes and links individuals to these services prior to their discharge.</p> <p>Several Peer Support Mentors are currently working through local CSBs</p>	
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		<p>providing peer support at Crisis Care Centers and a local group home. Work continues with the region on establishing a Peer-run Crisis Center; the NVMHI Director of Social Work co-leads a Peer Facilitation Training and is working with the Active Treatment Coordinator to provide peer-run active treatment groups, including ones that address transitioning to group home settings (WRAP groups).</p> <p><u>Final Outcome Measure (July 2009)</u> The 30 day readmission rate for consumers discharged to area group homes decreased from 6% in FY 2008 to 3% in FY 2009</p>	
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Other Areas Relevant to Enhancing Recovery
Goal: The facility will continuously look for other ways to increase the recovery experience.

<p><u>Strategy 1:</u> Expand discussions related to informed consent to include broader discussions of on-going medication use, choices and implications of decisions about types of medication and adherence to prescribed regime.</p>	<p><u>Final Outcome Measure:</u> 20% improvement on Pt. Satisfaction Survey at D/C, Q9.</p> <p><u>DUE DATE: July 2008</u></p>	<p><u>Baseline Measure (July 2007):</u> Pt. Satisfaction Survey at D/C, Q9 – 73%</p> <p><u>Interim Measure (Jan. 2008):</u> 10% improvement on NVMHI Pt. Satisfaction Survey at D/C, Q9.</p> <p>During treatment team meetings, the current medication regimen is discussed, the target symptoms reviewed, and how improvements will help the person in his/her recovery is discussed. If the person has concern about side effects, those are discussed as well. The discussion is expanded to include other choices as well as implications of adherence as the person indicates readiness and/or nears discharge.</p>	<p><u>Responsible Party:</u> Medical Staff led by Medical Director.</p>
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		<p>We did not meet our target based on the average score (67%) on Q9 of the Patient Satisfaction Survey at Discharge between 7/07 and 12/07; however, the target was met in the month of December 2007 (85%).</p> <p>July 2008 – FY 2008 cumulative data for Q9 of the Patient Satisfaction Survey demonstrated an average score of 64%.</p> <p>In addition to nursing medication education, each Service Area has a minimum of one medication education group per week led by a psychiatrist.</p> <p>The Pharmacy and Therapeutics Committee is currently reviewing the Informed Consent process, including forms and educational materials (including the use of pictures to educate consumers on side effects) to improve this aspect of care.</p>	
<p><u>Strategy 2:</u> Request that the A LOT group identify key deficit based/risk averse policies for CO revision.</p>	<p><u>Final Outcome Measure:</u> Identified policies revised to be aligned with concepts of choice, control, risk, and learning inherent in unexpected outcomes.</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measure (July 2007):</u> A LOT dialogue about need to address these policies.</p> <p><u>Interim Measure (July 2008):</u> Policies identified and prioritized with recommendations for revisions. A survey requesting feedback from senior management across facilities/CO on policies in need of revision in order to support Recovery and HPO philosophies was completed by the A LOT group during the past quarter.</p>	<p><u>Responsible Party:</u> CO and ALOT team</p>

		<p>The A LOT group is meeting with representatives from Central Office HPO group (“LEEP”) on Monday, August 11th for preliminary dissemination of results.</p> <p><u>Final Outcome Measure (July 2009)</u> Information from the ALOT survey was disseminated to the CO and throughout the facility.</p>	
<p><u>Strategy 3:</u> Continue with efforts to decrease aggression.</p>	<p><u>Final Outcome Measure:</u> 1) 50% reduction in the number of Pt-Pt Incidents and Pt-Staff Incidents. 2) 20% improvement on Pt. Satisfaction Survey at D/C, Q4. 3) 20% improvement on Consumer Interview, Q15.</p> <p><u>DUE DATE: July 2009</u></p>	<p><u>Baseline Measure (July 2007):</u> 1) Pt.-Pt. Incidents – 20 for the month. Pt. - Staff Incidents – 17 for the month. 2) Pt. Satisfaction Survey at D/C, Q4 –76% 3) Consumer Interview, Q15 – 61%</p> <p><u>Interim Measure (July 2008):</u> 1) 25% reduction in the number of Pt-Pt Incidents and Pt-Staff Incidents. 2) 10% improvement on Pt. Satisfaction Survey at D/C, Q4. 3) 10% improvement on Consumer Interview, Q15.</p> <p>There has been a 39% decrease in both Patient-Patient and Patient-Staff incidents between FY 2007 and FY 2008. The Patient Satisfaction Survey at Discharge Q4- 80% of consumers report that they usually or always feel safe in the hospital – a 4% improvement In late July and early August current aggression reduction interventions were again reviewed, tweaked and reinforced in various settings with clinical staff to support ongoing improvement.</p> <p><u>Final Outcome Measure (July 2009)</u> The Individual Satisfaction survey at</p>	<p><u>Responsible Party:</u> Senior leadership Team</p>

		<p>discharge Q4 has shown a 7% increase from baseline. 83% of individuals reported feeling safe in the hospital during FY 2009 (monthly range of 68% to 95%)</p> <p>The rate of aggressive incidents during FY 2009 was comparable to the baseline (2007) data. NVMHI continues to make strides in minimizing the use of seclusion and/or restraint as evidenced by a decrease in use during FY '09.</p>	
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