

Piedmont Geriatric Hospital

Plan for Improvements based on OIG report

Piedmont Geriatric Hospital values the detailed feedback from the Office of the Inspector General (OIG) regarding the continued systemic transformation to a recovery-based service delivery system. Staff members at all levels of service and leadership have been informed of the findings and many have provided input for improvements specific to PGH. This document discusses in brief Piedmont's plans for implementing changes recommended from the OIG.

The Role of Senior Leadership (general)

The role of senior leadership in the implementation of the principles of Recovery at Piedmont Geriatric Hospital is to provide the vision for full adoption of these principles, to provide the means to ensure that the principles can and will be adopted and implemented and to oversee the process to insure that the implementation is carried out in a timely, efficient manner that is consistent with the belief system that supports Recovery. To this end, a Recovery-based vision statement was developed for the hospital in 2005 and has been the basis for our mission since that time.

As a first step, the senior leadership initiated the formation of a Recovery Team in the autumn of 2005 to include senior leaders as well as representatives from all clinical departments to educate on recovery principles and to develop recovery assessment tools. In 2007, this team began re-evaluation of the existing patient recovery plans and assessments for further improvement to reflect that the concepts of recovery, self-determination and participation were included in treatment planning and service delivery. In June 2007, the leadership of the team was reconfigured to add the Hospital Director/CEO as co-chair. The Recovery Team is responsible for the development of the culture change within the hospital. At present, 4 workgroups have been established and chartered to initiate this change. They include the following:

1. Value Based Training – to ensure that the principles and values are inculcated throughout Piedmont,
2. Recovery Readiness – to ensure the transition from Treatment to Recovery planning and interventions by the caregivers and patients to focus the process to Recovery,
3. Flow Through – ensuring that the treatment and management of clinical operations through the hospital is consistent with the principles of Recovery and best practice, and
4. Consumer & Family Involvement – to develop means to increase the involvement of our consumers and their families in the Recovery process.

Each of these workgroups will routinely report their progress to the Recovery Team and then through them to the Hospital Leadership Team. Taken together, the activities of these workgroups will serve to act as the implementation of the PGH Comprehensive Plan on Recovery.

In June of 2007, a performance improvement team was chartered to develop and implement a comprehensive outcome measures plan for the Recovery effort (i.e., the Outcomes Committee, or OC). This team is comprised of members of the Senior Leadership Team including: the Facility Administrator, the Psychology Director, The Quality Manager and the Risk Manager. In the initial meeting this group determined that the outcome measurement matrix for review will be those recommended in the **Review of the Recovery Experience of Individuals Served at Mental Health Facilities Operated by DMHMRSAS** by the Office of the Inspector General. This approach is consistent with the DMHMRSAS response to those recommendations. Specific measurement approaches may be developed in each of these measurement domains to assure adequate progress toward our vision of Recovery for our patients. Regular, periodic reports on progress will be made by the OC to the Senior Leadership Team.

The Role of Senior Leadership	
Who	Director/CEO – Senior Leadership Team
What (Goal)	Develops vision and strategic initiative
When (Target Dates)	Initiated 2005, Revised 2007, Review annually as part of review of strategic plan and establishment of hospital annual goals
How (Strategies)	Establish Recovery Team, Establish Outcomes Committee for Recovery effort
Evaluation Method (Tool)	Score Card - Measurement matrix based on OIG developed measures (See Report # 137 – 07)
Sources of Data for Evaluation	<ul style="list-style-type: none"> • Workgroup & Committee minutes, • Training records, • Patient interview and survey results, • Unit Observation Checklists, • Staff Interviews, • Treatment Team Observation checklists, • Psychosocial Activity Observation Checklists.
Frequency of Evaluation (to include 2007-2009)	Semi-Annual for FY 2007 – 08, 2008 – 09, 2007 - 2010
Measure of Success Goal	Semi-Annual Increases above initial baseline scores over 3 years in positive scores on Score Card measures.

Workforce Development (findings 5, 15-21)

An additional training curriculum will be developed for clinical staff to provide reorientation on recovery values. This mandatory training will help to address OIG Recommendations #5 and #15-21. Training will be begin October 1, 2007, and will include the following:

- a review of the principles of recovery
- use of recovery-oriented language
- recognizing characteristics of persons in recovery
- understanding the path of recovery to include relapses and setbacks
- recognizing and respecting patient opinions and perspectives

- reinforcing the clinical advantages of a facility recovery culture
- identifying how the environment has changed to be more recovery focused or introducing strategies to transform the environment
- making efforts to involve and engage patients in treatment team conferences, programs, activities, or other opportunities involving valued roles
- offering patient choice whenever possible (e.g., meal, sleep, room, treatment plan, program, discharge planning, and medication choices, etc.)
- encouraging patients to do what they can do for themselves
- viewing the patient as a person experiencing mental health problems rather than a mentally ill person
- the importance of patient support in the hospital and in the community
- introduction and assignment of staff to serve in patient coach roles to foster supportive connections and helping relationships
- the role of professionals in encouraging patients to take risks

Specifics of workforce development plans, to include responsibilities, goals, target dates, strategies, and evaluation, are included in the table below.

Workforce Development Plan	
Who	Value-Based Training Subcommittee of the PGH Recovery Committee
What (Goal)	To reorient all clinical staff on recovery principles and practical applications through additional mandatory training. Additional educational sessions will be shared with hospital administration, department and unit staff, and offered to CSBs, patients, and families.
When (Target Dates)	First training to begin 10/1/07 for recovery trainers. Other staff training to follow in November and December 2007. Training to be concluded by January 2008.
How (Strategies)	<ul style="list-style-type: none"> • Development of training plan to include: an overview of the mission, purpose, philosophy, and principles of recovery; the clinical advantage; re-introduction to steps of recovery; environment and awareness; coaching; characteristics of a person in recovery; characteristics of staff involved in recovery; and evaluation of competencies. • Reinforcers will be used such as: development of a recovery tool kit for trainers, using the train-the-trainer concept; use of logos, designating a Recovery Month; posting recovery values as an additional reference for staff, patients, families.
Evaluation Method (Tool)	<ul style="list-style-type: none"> • Evaluation of competencies;

	<ul style="list-style-type: none"> • Evaluation of staff interviews using OIG Staff Interview assessment tool; • OIG Unit Observation Checklist assessment tool.
Source of Data for Evaluation	Aggregation of information from competency tools and staff interview and unit observation assessment tools (using random sampling method).
Frequency of Evaluation (to include 2007-2009)	<ul style="list-style-type: none"> • Training and competencies to be evaluated at conclusion of training; • Staff interview and unit observation tools to be administered post-training and repeated again quarterly thereafter.
Measure of Success Goal	<ul style="list-style-type: none"> • Staff training: 95% > of clinical staff to be trained by Jan 2008, • Staff assessment tool: increases over 3 years above the initial baseline, approaching 100%, • Unit observation checklist: increases in positive ratings over 3 years above initial baseline, approaching 100%.

Design of the Clinical Record (finding 6)

Piedmont recognizes that much of the service delivery process is guided by the design of its supporting documentation. As such, early efforts to infuse recovery concepts into PGH care (circa 2006) focused heavily on the design and implementation of the “Recovery Plan”— a treatment plan-style document that requires treatment teams to account for 10 dimensions of a person’s care (e.g., family support, education, stigma) rather than providing more narrow-scoped treatment under the broad headings of “psychiatric” and “medical” interventions. The Recovery Plan was completed in addition to, but not as part of, the Master Treatment Plan (MTxP). Initial feedback about the Recovery Plan after several months of use, along with recommendations from the Office of the Inspector General, has motivated PGH to re-design the entire MTxP.

The new MTxP, entitled the Recovery Treatment Plan, is currently in development. A subcommittee of the PGH Recovery Team, consisting of representatives from all clinical disciplines plus Health Information Management personnel and administrative support, has completed an initial draft of this document. The new Recovery Treatment Plan treats recovery concepts as centrally important to the treatment planning process rather than peripheral to it. It includes a balance between strengths and deficits and more fully promotes person-centered/directed planning than the previous MTxP. Patient and/or Legally Authorized Representative input is actively solicited, considered, and clearly documented in the treatment plans. Specific changes inherent in the new Recovery Treatment Plan are numerous, and include the following:

- Changing the title from “Master Treatment Plan” to “Recovery Treatment Plan” to continue to promote a recovery philosophy of care;

- A statement on the front page requiring treatment team members to assess and document whether or not the patient understands his/her reason for admission;
- A forced-choice item requiring treatment team members to assess and document “To what extent can the patient participate in the initial Recovery Treatment Plan?”;
 - to discourage an all-or-none view of patient capability (i.e., yes/no), a spectrum of choices is provided, and includes the designations “Full”, “Moderate”, “Partial”, “None”, and “Refused”
 - these designations correspond directly to the terminology used on the “Participation/Review” form that documents patient and LAR involvement in the treatment planning process, providing an opportunity to monitor progress over time;
- Section formerly entitled “Current and Psychiatric Behavior Problems” changed to “Focus of Hospitalization” in order to try to remove the pejorative connotation of a person’s reason for admission and continued hospitalization;
- “Problems” are now referred to as “Challenges”, implying that they may be overcome;
- “Strengths” and “Cultural needs/challenges”, both as identified by the patient/LAR and by the Recovery Team, are now more explicitly addressed and emphasized in their own section;
- A new section, entitled, “Positive Expectations” is added, and includes, in the individual’s own words, statements of dreams, hopes, aspirations, role functions, and vision of life;
- Another new section, entitled “Discharge Goals for Anticipated Placement” is included, documenting goals generated by both the patient/LAR and the Recovery Team;
- The treatment plans themselves are completely redesigned, and each plan includes the following components:
 - Explicit description of each behavioral objective, measurement strategy, and anticipated dates of completion;
 - Scheduled updates of Recovery Phase (Engagement, Developing Readiness, Decision-making, Role Recovery) and Objective Status for each team conference
 - A new section entitled “Patient Strengths that Aid Interventions”
- Additions to the “Participation and Review Sheet” section that include team assessment of level of patient/LAR participation for each conference (Full, Moderate, Limited, None, Refusal), acknowledgement that the various Recovery Domains and the patient’s needs upon discharge were discussed during the conference;

Design of the Clinical Record (Finding 6)		
Who	Recovery Plan Subcommittee of the PGH Recovery Committee.	
What (Goal)	Convert clinical record-keeping to a format more consistent with Recovery/person-centered treatment philosophy.	
When (Target Dates)	8/07	Approve working draft (Recovery Committee)
	9/07	Pilot new document in limited use (selected treatment teams)
	10/07	Final revisions and approval by Recovery

		Committee
	11/07	Training for all program teams (Recovery Plan Subcommittee during regularly scheduled Program Team meetings)
	12/07	Formal “roll-out” (all new admissions using new Recovery Treatment Plan; all current patients begin conversion to new plans)
	2/08	All patient care at PGH guided by new Recovery Treatment Plan (100% compliance)
How (Strategies)	Substantially revise MTxP document to promote Recovery concepts.	
Evaluation Method (Tool)	<ul style="list-style-type: none"> • Audits to insure conversion (existing patients) and implementation (new admissions) of new format; • OIG Record Review assessment tool. 	
Source of Data for Evaluation	<ul style="list-style-type: none"> • Compliance audits post-implementation; • Random sample of Record Reviews. 	
Frequency of Evaluation (to include 2007-2009)	<ul style="list-style-type: none"> • Compliance will be reviewed following full implementation of conversion process; • Record Review data will be collected quarterly by randomly assigned clinical and non-clinical staff (non-Recovery Committee members) to gauge the need for process improvements or further training. 	
Measure of Success Goal	<ul style="list-style-type: none"> • Complete conversion over to new format (goal = 100% conversion/compliance by February 2008); • Record Review increases in positive ratings over 3 years above initial baseline, approaching 100%. 	

This format of the clinical record should be able to tie into many broader forms of electronic medical records. Its tabular format is conducive to the use of strategically placed form fields and links to available databases (e.g., AVATAR).

Treatment Planning (findings 1-6)

As mentioned above, the MTxP is in the process of being updated to reflect core recovery principles. The new Recovery Treatment Plan provides teams the opportunity to demonstrate that patient presence, input, preferences, and holistic well-being are solicited and accounted for during the treatment planning process.

Apart from the substantial changes to the principle treatment planning document, expectations regarding the actual execution of the treatment planning process will be clarified in an upcoming PGH Hospital Instruction (HI). The new HI is expected to reinforce the Recovery-based culture

changes already put into place, and to provide guidance on changes intended for the future. Although the specifics of the HI remain undetermined (due to the evolving and dynamic nature of such an initiative), the areas most likely to be addressed are listed below:

- non-PGH persons who would be required to be present for team conferences to be held (e.g., patient and/or LAR, CSB liaison, etc.);
- PGH staff required to be present (e.g., all clinical disciplines, including DSAs, dietary services staff, etc.);
- use of “person-first” language;
- increased focus on life post-discharge from PGH;
- increased emphasis on hope and positive expectations toward patients;
- decreased focus on symptoms, behaviors, and medical issues in the absence of attention to other facets of the individual;
- use of a Recovery Coach to assist the patient through the treatment planning process;
- environmental and logistical considerations (e.g., days, locations, times, and length of conferences); and
- team leadership considerations (e.g., dividing up nominal leadership from group facilitation role).

These areas may change as the HI development process unfolds. Following development of this HI, each addressed area will become its own subproject, meriting an action plan that includes responsible persons, strategies, measurable objectives, and target date(s) for completion. The HI will also make appropriate references to other already-present Recovery-based entities and initiatives, such as the Recovery Committee and the Recovery Treatment Planning process.

Treatment Planning (Findings 1-6)		
Who	PGH Recovery Outcomes Committee (OC) & PGH Leadership Team (LT).	
What (Goal)	Creating and requiring compliance with a new and highly publicized hospital policy (i.e., Hospital Instruction, or, HI) for Treatment Planning in order to promote a more person-centered therapeutic experience for PGH patients.	
When (Target Dates)	1/08	OC determines HI contents, develops initial HI draft, submits to relevant hospital committees for input and approval.
	3/08	<ul style="list-style-type: none"> • LT approves New and finalized HI • New HI distributed and communicated to current PGH staff (i.e., training) via newly established communication channels (LT to RC to Program Teams—based on High Performance Organization principles) • Data collected on treatment

		planning process (random sample) and compared to baseline OIG measure.
	5/08	Strategic plan for implementing all aspects of HI (i.e., subprojects) not already put into place developed and finalized.
	8/08	Reports on overall progress of implementation due to OC and LT.
	11/08	<ul style="list-style-type: none"> • All aspects of HI implemented • Serial measure of progress taken • Re-evaluation of process and/or HI based on findings.
	Ongoing	Specifics of HI included in Hospital Director's section during monthly scheduled new employee orientation.
How (Strategies)		<ul style="list-style-type: none"> • Conferences between LT, OC, and Recovery Committee to assist in generating PGH-specific culture change priorities regarding treatment planning • Creation of new HI document and passage through LT • Organizing training for all PGH clinical staff implementing strategies outlined in new HI.
Evaluation Method (Tool)		<ul style="list-style-type: none"> • OIG Treatment Team Observation Checklist • Percent of clinical staff trained on new HI.
Source of Data for Evaluation		<ul style="list-style-type: none"> • Random samples of treatment team observations by non-clinical staff (for objectivity) • PGH training records.
Frequency of Evaluation (to include 2007-2009)		<ul style="list-style-type: none"> • Quarterly through FY 2008 • Following HI implementation, then monthly for each cadre of new employees oriented (i.e., after each orientation session).
Measure of Success Goal		<ul style="list-style-type: none"> • Reach and maintain 85% positive response rate on Treatment Team Observation Checklist • Percent completion toward implementation and communication of new HI (goal = 98%).

Resident Activities and Opportunities (findings 7-12, 22)

There are several opportunities for consumers to provide regular, timely feedback about their satisfaction with treatment and conditions at the hospital. Community Morning Meetings on the unit allow patients the opportunity to discuss their immediate problems or concerns. Patient Council, which convenes monthly, is an opportunity for patients to meet with the advocate, hospital director, and other departmental representatives. Treatment Team Conferences are scheduled bi-monthly for the first sixty days after admission and then monthly. The team also meets as needed. It is an opportunity for clinical staff to share the Treatment Plan with the

patient and allows the patient an opportunity to be a participant in the planning process. Patient Satisfaction Surveys are distributed annually and upon discharge and allow the patient and/or LAR an opportunity to provide feedback about their experiences here at the facility.

In the future, we would like to provide Recovery Coaches to prepare patients for team conference and to follow-up with the patient afterwards regarding groups and activities that are available. The coaches would also provide additional information about the discharge process. We want to continue supporting patients as they strive to participate in planning their individual service plan. Copies of the plan will be given to the patient and they would then have the opportunity to review it and to sign a form stating that they will partner with the team and clinical staff in order to reach the recovery goals.

The ability to choose has become one of the hallmarks for the Recovery Program at Piedmont. The facility currently has a wide variety of PSR program activities including

- Skill building (socialization, reminiscence, diversional, arts & crafts, community trips)
- Sensory & tactile stimulation
- Physical exercise
- Spiritual groups
- Leisure education and awareness
- Cognitive therapy
- IADL groups
- Restorative nursing
- Music therapy

Although there are some restrictions based on needs for discharge and commitment status, we would like to provide the opportunity for the consumer to choose between morning and/or afternoon group activities as well as which programs they wish to participate in from a list of options. Eventually, with increased staff, they will have the chance to decide which therapist they would like to work with.

Our staff currently provides numerous environmental and social support systems. The facility recently purchased furniture items for the lobbies and north dining room, in addition to new beds, and dressers for patient rooms, in an attempt to provide a more home-like environment. When patients are not involved in programs, they have the option of watching a movie from the video library, viewing a program on cable television, playing board games, bingo or other interactive games with staff, or choosing reading material from the selection of novels and magazines. Family members currently attend team conferences and are therefore aware of and involved in the programming, treatment, and recovery plans. Future plans include the use of a recovery coach to explain key components of the recovery plan at the facility, help patients to convey their questions, concerns and goals to the treatment team prepare patients for team conference and perform timely follow-up, be available as needed to come and assist the patient and serve in a supportive role, and help the consumer feel safe and comfortable in the facility.

We also strive to assist our patients in participating in areas where they feel valued. Our plans include having patients from other units come to 2W to read to the patients there and providing opportunities for consumers to volunteer in the clothing room, gift shop, library or assist with

newspaper distribution. In the style of wrap programming, we also plan to invite former consumers to come to PGH and share their experiences and to offer support.

Resident Activities and Opportunities (findings 7-12, 22)	
Who	Clinical staff (Psychiatrist, RN, Social Worker, Psychologist, RT, OT), patients and/or family members), patient advocate
What (Goal)	Ensuring active participation and decision making of patient and LAR in recovery process
When (Target Dates)	8/07 Identify members and gather resources for Recovery month
	9/07 Plan activities for Recovery month and distribute brochures to families
	10/07 Recovery month, training starts for “trainers”
	11/07 Training for everyone (LARs, family members, patients, etc)
	12/07 Training continues
	1/08 Complete Training
	10/08 Month of recovery events, including a Carnival
How (Strategies)	<ul style="list-style-type: none"> Continued communication and information exchange via patient council, team conferences, recovery coaches, Recovery training provided for hospital staff, patients, and family members
Evaluation Method (Tool)	<ul style="list-style-type: none"> Family and patient surveys distributed annually and upon discharge Review of Patient Status Form Patient/Family Participation Form Attendance (Signature) Form for each conference Strengths and Limitations Form Teams'/patients'/families' participation in conference Satisfaction surveys for each activity
Source of Data for Evaluation	<ul style="list-style-type: none"> Minutes of last meeting Monthly progress notes Treatment team notes Notes in recovery plan
Frequency of Evaluation (to include 2007-2009)	Data will be collected monthly and analyzed quarterly by the Recovery Committee to gauge the need for process improvements or further training
Measure of Success Goal	<ul style="list-style-type: none"> Results from family/LAR surveys, reflecting active participation of patients and family or significant other

	<ul style="list-style-type: none"> • Annual increases over 3 years above initial baseline approaching 100%
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Relationship to the Community (finding 13)

Although we acknowledge that the patients served at PGH face some difficulty with involvement in community employment and volunteer activities due to physical limitations of age and physical medical status, we believe that each should function to the maximum that his/her condition and wishes will allow.

We, at PGH, take pride in developing our culture of Recovery within the hospital and our hospital community. We provide a Discharge Planning and Sharing Conference with regional CSBs, ALFs/NHs, families and staff at least once yearly. Family education programs are held at least annually. Family Connection Newsletter is sent out at least twice a year.

We have actively engaged with Chase City Nursing Home in a unique and inventive process to develop a partnership with them to place consumers who have a variety of special needs making them difficult to place in the community. Through this process, we provided the following:

- Pre-admission Team meetings to develop interim care plans;
- An available staff member (Social Worker) to attend to transition care planning conferences;
- Ongoing monthly team meeting for the first 3 months and quarterly thereafter;
- Chief Nurse Executive offered training to CNAs and Nursing;
- Clinical Psychologist provided support and consultation as needed;
- Developed a monitoring form with the Nursing Home to provide needed data to track behaviors for behavioral interventions;

From the time of implementation of the Chase City partnership, PGH was instrumental in working with the patient's CSB and the Community CSB to get services for patients with behavioral needs. We are in discussions with other Nursing Home providers to develop similar consultative, educational relationships.

We are in process of developing an "Interagency Therapeutic Program Proposal for a Community Transitional Program" with Crossroads Community services Board. This program will when developed provide community based day psychosocial rehabilitation services for "high risk of unsuccessful discharge" patients from PGH. The PGH patients referred and accepted by this offering will be integrated into the psycho-social treatment activities.

PGH will benchmark with Catawba Hospital, most similar to us in size, mission and configuration and recognized in the **Review of the Recovery Experience of Individuals Served at Mental Health Facilities Operated by DMHMRSAS** as one of the 3 hospitals noted to "do better with volunteer roles" and offering opportunities for the experience of paid employment near the hospital to seek opportunities for enhancement for our patients.

At present, PGH is developing enhanced in-hospital volunteer opportunities. The Community and Family Involvement Workgroup chartered by the Recovery Team is planning a month long

Recovery month for October 2007. 3 patients are active participants in this planning process. The theme of the Recovery month program is “Stigma Busters”.

We will look to the relocation of VCBR to our campus for increased opportunities for employment and/or volunteer service.

PGH will investigate developing volunteer and paid employment opportunities for clients from Crossroads Community Services, our local CSB, to provide enhanced options for community involvement for the clients of this local agency.

In addition, we will work with the Piedmont Geriatric Institute to seek opportunities for select patients to share their knowledge, skills and abilities with the recipients and attendees at the Institute’s community educational offerings.

We will specifically monitor the numbers of patients involved in volunteer and community employment related activities and seek to increase that number in each review period.

Relationship to the Community (Finding 13)	
Who	Recovery Team, Community & Family Involvement Workgroup, PGH Social Work Dept, Piedmont Geriatric Institute
What (Goal)	Enhanced opportunities for community involvement and re-integration
When (Target Dates)	Ongoing & Annual , Recovery Month)Ct 2007,
How (Strategies)	<ul style="list-style-type: none"> • Consumer Involvement in Planning, • Implementation & Development of Recovery related activities and training, • Enhanced Community Involvement for consumers from PGH and local CSBs, • Develop enhanced opportunities to receive non-hospital level services for PGH consumers, • Incorporation of VCBR into the PGH hospital community for PGH consumer involvement, • Investigate consumer involvement into PGI activities, • Benchmarking with Catawba hospital (recognized by OIG) to develop best practices for enhancing volunteer and community involvement opportunities for our shared specialty service population.
Evaluation Method (Tool)	<ul style="list-style-type: none"> • Counts of consumers involved in Planning, • Implementation and Development activities, • Numbers of consumers involved in non-hospital level community services, • Numbers of new volunteer opportunities (sites)

	<p>available,</p> <ul style="list-style-type: none"> • Numbers of consumers involved in volunteer activities,
Source of Data for Evaluation	Surveys, interviews, minutes, activity records, volunteer site records
Frequency of Evaluation (to include 2007-2009)	<ul style="list-style-type: none"> • Quarterly reports by the Community & Family Involvement Workgroup to the Recovery Team • Quarterly Report from Scorecard by Outcomes Measurement Group to Leadership Team • Semi-annual evaluation by Leadership Team (FY 2007-08, FY 2008 - 09, FY 2009 - 10)
Measure of Success Goal	Semi-annual percentage increases above initial baseline over 3 years of Involvement in Community and Family Involvement on Score Card Measures

Other Relevant Areas (findings 14, 15, 23, 24)

We will continue to market the Recovery mission of the facility so that staff, patients, family members and visitors are familiar with the vision. We can do this via posters, t-shirts, newsletters, public events. The future goals of the recovery program include the implementation of groups that emphasize preventive health, development of social skills, community awareness and resources, medication awareness, illness management, money management, problem solving, time management, and renewed hope and empowerment.

Other Relevant Areas (findings 14, 15, 23, 24)	
Who	Recovery Committee
What (Goal)	Ensure that Recovery is an important part of the culture at Piedmont Geriatric Hospital
When (Target Dates)	10/07 Month of recovery events
	11/07 Training for everyone (LARs, family members, patients, etc)
	12/07 Training continues
	1/08 Complete Training
	10/08 Month of recovery events, including a Carnival
How (Strategies)	<ul style="list-style-type: none"> • Continued marketing of the Recovery mission of the facility so that staff, patients, family members and visitors are familiar with the vision. • Recovery training provided for hospital staff, patients, and family members
Evaluation Method (Tool)	<ul style="list-style-type: none"> • Family and patient surveys • Review of Patient Status Form • Patient/Family Participation Form • Attendance (Signature) Form for each conference

	<ul style="list-style-type: none"> • Strengths and Limitations Form • Teams'/patients'/families' participation in conference • Satisfaction surveys for each activity
Source of Data for Evaluation	<ul style="list-style-type: none"> • Minutes of last meeting • monthly progress notes • treatment team notes • notes in recovery plan
Frequency of Evaluation (to include 2007-2009)	Data will be collected monthly and analyzed quarterly by the Recovery Committee to gauge the need for process improvements or further training
Measure of Success Goal	<ul style="list-style-type: none"> • Results from family/LAR surveys, reflecting active participation of patients and family or significant other • Annual increases over 3 years above initial baseline approaching 100%