Person-Centered Planning (PCP) Quality Indicators

As part of a broader effort in the State of California, our agency is working to re-design our services so that they are maximally consumer-centered, and driven by the needs and preferences of the people we serve. One important part of this effort is thinking about both the process and documentation of treatment / recovery planning. Please use the below quality indicators checklist to evaluate the presence/absence of key PCP documentation indicators.

Person-Centered Planning Indicators: Documentation Quality			
Item	**Documentation Indicator**	**Yes**	**No**
B1	The assessment (can include a psychosocial assessment/ assessment update/narrative summary /comprehensive psychiatric rehabilitation assessment, etc.) includes the person's strengths. Strengths include, but are not limited to: environmental strengths, positive previous treatment experiences, interests/ hobbies, abilities and accomplishments, unique individual attributes, recovery resources/assets. Also includes, supportive relationships, positive family dynamics, abilities and accomplishments (educational attainment), developmental factors, cultural factors and preferences.		
B2	The plan/plan update actively incorporates the person's identified strength's to help achieve the short-term goals and desired results.		
B3	The narrative summary includes the following elements: 1. A clinical hypothesis/understanding/core theme regarding what drives the individual's experience of illness and recovery (critical item to include) 2. Strengths, interests, and current and/or desired life roles and priorities 3. Any interfering perpetuating factors, e.g., trauma history (strain in relationships), co-occurring medical or substance use disorders, etc. 4. Individual's stage of change and or developmental factors (developmental capacities) 5. Available natural supports or community resources (supportive relationships in a child's life) 6. Cultural factors and any impact on treatment		
B4	The short-term goal statements on the plan/plan update are about having a meaningful life in the family and the community, not only symptom reduction or compliance.		
B5	The plan/plan update includes accessible interventions beyond the paid professional clinical/rehab services and notes self-directed action steps/and/or action steps by natural supporters. (Note: These are typically identified within the assessment process and build upon the person's strengths.)		
B6	The plan/plan update uses "person-first" family-friendly language that is understandable and confers no blame (i.e., a *person living with schizophrenia* NOT a *schizophrenic)* that is empowering and positive and uses the person or families names throughout the document.		
B7	The plan/plan update is developed collaboratively and there is evidence of direct input from the person and/or family, e.g., includes quotes from the individual and/or statements such as "Jose stated…"		
B8	There is evidence in the record that the person or family was offered a copy of their plan. (Note: This may be found in a progress note following the planning meeting or directly on the plan itself.)		
B9	The target dates of short-term goals on the plan/plan update are individualized rather than all objectives defaulting to a standard update cycle, e.g., every 90 days.		
B10	The plan/plan update describes attempts to help the person to connect with chosen activities in the community rather than relying on social supports coming solely from mental health agencies.		

This tool is derived from the quality indicator tool developed by Janis Tondora, Psy.D (janis.tondora@yale.edu) and Diane Grieder, M.Ed (diane@alipar.org) 2011.

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