

# *Person Centered Individual Service Planning*

presented by

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# *Person Centered Individual Service Planning*

## **Presentation objectives**

- **Basic principles of the Person Centered Approach**
  
- **How to use the Person Centered Approach in writing the Individual Service Plan [ISP]**
  - At Assessment
  - When developing and updating the Individual Service Plan [ISP]
    - Goals, Objectives, and Interventions
  - During Discharge Planning
  
- **Using the Person Centered Approach in Service Coordination**

*Basic principles of the  
Person Centered Approach*



*Too often the creation of the individual service plan or plan of care is not fully inclusive of the member.*

**Healthcare professionals often make the mistake of:**

- Assuming to know what is best for the client.
- Not sharing the assessment/diagnosis results.
- Not communicating and making shared decisions.
- Dismissing the member's preferences and goals.
- Fostering dependency rather than self-reliance and recovery.
- Preparing the Service Plan without the member/family.

**Why are these things a mistake?**

It invalidates the person's experiences, damages the relationship, and decreases the chances of a positive outcome of the treatment process.

**Use of a person centered approach has been shown to improve treatment outcomes for clients.**



# *Tenets of the Person Centered Approach*

- Emphasizes the uniqueness of each person and each person's right to self-determination.
- Is based on the values of wellness, recovery, and hope.
- Views the relationship with the member / family as a partnership that supports the member's hopes, dreams, and goals.
- Creates a shared vision between the member and the provider.
- Is a process based on the member's / family's wishes and needs; not predetermined outcomes such as medication use, compliance, abstinence or stability.
- Speaks in strengths based and recovery language.
- Believes in working together to identify barriers and roadblocks to reaching goals. These are considered to be things standing in the way rather than as a pathology.

# Choose Your Words Carefully

“The words you use to write about mental health are very important, and can help reduce stigma around mental illness if carefully chosen. Focus on the person, not the condition.

- The basic concept is that the mental health condition (or physical or other condition) is only one aspect of a person’s life, not the defining characteristic.
  - *Preferred: She is a person with schizophrenia.*
  - *Not preferred: She is schizophrenic.*
- Be specific. Mental illness is a general condition. Specific disorders are types of mental illness and should be used whenever possible.
  - *Preferred: He was diagnosed with bipolar disorder*
  - *Not preferred: He was mentally ill*
- Avoid derogatory language. Terms such as psycho, crazy and junkie should not be used. In addition, avoid words like “suffering” or “victim” when discussing those who have mental health challenges.
  - *Preferred: She has a mental health illness. She has a substance use disorder.*
  - *Not preferred: She suffers from mental illness. She’s a drug abuser.”*

American Psychiatric Association (APA) . *Words Matter: Reporting on Mental Health Conditions.*  
Retrieved from <https://www.psychiatry.org/newsroom/reporting-on-mental-health-conditions>

# *Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery*

*authors Neal Adams, M.D., M.P.H., and Diane Grieder, M.Ed.*

“...the person-centered approach emphasizes the development of partnerships between clients and providers. All aspects of person-centered treatment planning rely on shared decision making and client-defined outcomes...this process promotes client choice, empowerment, resilience, and self-reliance.”

“Rather than relying on cookie-cutter plans whose primary target is to reduce the symptoms that make up the client's diagnosis, person-centered treatment plans are holistic, are highly individualized, and identify positive outcomes based on clients' strengths and available supports.”

# *Building a Plan* \*Adams & Grieder





*How to use the Person Centered Approach in  
writing the Individual Service Plan*



# *Person Centered Assessment*

**The assessment process can be viewed as a journey of discovery for both the member and the provider. It is an opportunity to build a respectful, collaborative partnership that is the foundation for a person centered service plan.**

- Meets the member/family where they are
- Views the member/family as the expert on themselves
- Demonstrates a welcoming environment
- Values choice, self-determination, and empowerment
- Gathers information about the needs and preferences of the member as it relates to the delivery of the specific service.



# Person Centered Assessment [cont]

The following questions are provided as suggestions for initiating a strengths-based, person-centered dialog as part of the Assessment Process.

**Personal Strengths:** e.g., What are you most proud of in your life? What is one thing you would not change about yourself? What positive things would others say about you?

**Interests and Activities:** e.g., If you could plan the “perfect day,” what would it look like? What kinds of things would you be doing? What kinds of things do you like learning about?

**Living Environment:** e.g., What are the most important things to you when deciding where to live?

**Employment:** e.g., What would be your ideal job? What skills do you need to do this job? Which of these skills do you already have? Which skills do you need to develop?

**Trauma:** e.g., Tell me about experiences/relationships/people that make you feel safe/not safe. What experiences/relationships/people have supported you to reach your personal goals? How have other experiences/relationships/people made it more difficult for you to reach your goals?

**Safety and Legal Issues:** e.g., Tell me about your experiences with the police and the legal system. How have the police been helpful/not helpful to you? Tell me about times you have had to go to court. Tell me about situations that make you feel safe/not safe.

**Financial:** e.g., What level of independence do you have in managing your finances? What skills, supports, or information do you need to be more independent?

# Person Centered Assessment [cont]

**Lifestyle and Health:** e.g., What is your health like? Tell me about the things you do that help you stay healthy. What are some things you would like to do to improve your health?

**Choice-Making:** e.g., What are some of the choices that you currently make in your life? What choices would you like to make for yourself that others are making for you? If you could make these choices, what would you choose differently?

**Transportation:** e.g., How do you currently get from place to place? What would make travel easier/more affordable/less stressful for you?

**Faith and Spirituality:** e.g., How do you view the purpose of your life? What spiritual or faith-based activities do you participate in? In what ways are these helpful to you?

**Relationships and Important People:** e.g., Is there a person in your life that you feel believes in you? Who is that person? In what ways does this person convey this belief in you?

**Hopes and Dreams:** e.g., Tell me a bit about your hopes or dreams for the future. What are some hopes and dreams that you have let go of? Tell me about the dreams that have come true for you. What did you do to make these dreams come true?

# Person Centered Planning: Individual Service Plan

- The ISP is a comprehensive and regularly updated document that integrates both physical and behavioral health, service coordination and integrated care goals specific to the needs of the individual being treated and meeting the defined specific service requirements. [CMHRS manual Chap IV pg 17]
- Is based on the understanding of the person gained during the assessment
- Is the road map for the work to be done by the member, family, and provider
- Emphasis in person centered service planning is on the strengths and preferences of the member rather than the problems or the deficits.
  - Use of the member's strengths is how life goals and dreams will be achieved
  - Barriers are the roadblocks that interfere with achievement of the goals. Barriers are not the exclusive focus of the plan.
- Focuses on the member's life vision by incorporating his/her hopes, dreams, and goals.



# Person Centered Planning: Individual Service Plan [cont.]

- As emphasized in the Psychiatric Services Provider Manual [Chap IV, pages 7-9], it is critical that the Initial Plan of Care and the Comprehensive Individual Plan of Care [CIPOC] be developed by a team of professionals in consultation with the individual and the individual's parents, legal guardians, or others in whose care the individual will be released after discharge.
- Participation in the specific service should not be a goal or objective when writing the Individual Service Plan.
- However with Therapeutic Foster Case Management [TFC-CM], a provider's program of therapies, activities, and services should be documented in the individualized comprehensive treatment plan [Psychiatric Services Provider manual Chap IV page 20], including
  - The specific methods of program therapies, activities, and services,
  - The specific methods of interventions and strategies designed to meet the above goals and objectives
  - Describing how the provider is working with related community resources to ensure a continuity of care with the individual's family, school, and community
- One of the requirements in written progress Reports for TFC-CM is including 'The individual's assessment of his or her progress and his or her descriptions of services needed, where appropriate.' [Psychiatric Services Provider manual Chap IV page 20]

# Person Centered Goals

Goals: Should reflect an individualized specific overview of the objectives and will address the larger presenting needs. Goals are longer term than objectives.  
[as defined in the CMHRS Manual Chap IV page 17-19]

- Long term, global, broadly stated
- Provides a meaningful motivational statement that reflects what the member would like to achieve
- Is simply stated and ideally expressed in the member's own words
- Is easily understood
- Is written in positive terms
  - Traditionally goals focus on deficits, behaviors, limitations such as “improve compliance” or “reduce behaviors”



# *Person Centered Objectives*

Objectives: Should demonstrate shorter term, measurable, achievable, action-oriented, strength based activities that the individual/family will engage in toward completion of the goal. [CMHRS Manual Chap IV page 19]

- Should be observable actions on the part of the member and/or family. Objectives should be behavioral rather than process orientated
- Describes the attainment of new skills, abilities, or accessing of new supports
- Focus is on skill development, decision-making, and enhancing self-management
- Plans should only have a few objectives to work on at a time





# Person Centered Interventions

Interventions: are developed based on the member's specific strengths , preferences, and needs (such as developmental level, level of functioning, academic/literacy ability, interests, etc.)

- Define specific steps that the member, family, and/or the provider will engage in toward the attainment/achievement of each objective
- Clearly reflect service coordination amongst all parties involved in the provision of care to the member.
- Explain the methods or services, who is going to do what and how
- It is the agreement on the kinds of services, activities, supports and resources the member needs to achieve the short term objectives.
- Parent and Caregiver objectives included in IIH services must be related to increasing functional and appropriate interpersonal interactions with the individual authorized to receive services and must include the individual-specific program purpose of the goals to be achieved within the authorized time period. Intensive In-Home providers must ensure that all interventions and the settings of the intervention are defined in the Individual Service Plan. [CMHRS Manual Chap IV page 17-19]



# *Frequency AND the Person Centered ISP*

- The frequency with which the overall service will be provided to accomplish the measurable goals and objectives identified is an essential part of the ISP.
- The ISP must be reviewed by the service provider, at a minimum, on a quarterly basis to determine if the goals and objectives meet the needs of the member based on the most recent clinical review of the service documentation and assessment of functioning.
- Adjusting the frequency of service provision and ISP review is expected to be done when progress is determined, new opportunities for improvement emerge, and growth is seen building upon existing strengths.
- The review of progress as well as any changes to the ISP must be documented in the quarterly report. All revised service plans must be signed by the individual and/or family.  
[CMHRS Manual Chap IV page 19]

# *Target Dates in the Person Centered ISP*

A person-centered, recovery-focused approach to treatment planning has target dates that are relevant to the scope of the objective, the member's and family's motivation and the resources available to support and facilitate the change.

## **Target Dates in the ISP should:**

- Be specific to each objective
- Predict how long it will take the member to achieve the change
- Motivate actions and organize energies

The target dates established for objectives carry an important message for the provider as well as the member:

***Change is Expected!***

# *Signatures on Person Centered ISPs*

- The child's or adolescent's ISP shall also be signed by the parent/legal guardian and the child/member when possible; The adult member shall sign his/her own ISP.
- If the individual, whether a child, adolescent, or an adult, is unwilling to sign the ISP, then the service provider shall document the clinical or other reasons why the individual was not able or refuses to sign the ISP [CMHRS Manual Chap IV page 18].
- Signatures shall be obtained unless there is a clinical reason that renders the individual unable, the individual refuses to sign or is unwilling to sign the ISP. [CMHRS Manual Chap IV page 18].
- Not obtaining the member's signatures at the time the ISP is created or at any time the ISP is updated or changed is **not** exemplifying a person-centered approach to service planning.



*Using the Person Centered Approach in  
Service Coordination*



# *Service Coordination and Continuity of Care*

## Service Coordination:

- All ISPs should clearly include service coordination as necessary toward the attainment of the objectives [CMHRS Manual Chap IV page 19]
- Service coordination activities must be defined as related to the specific treatment needs and the related service goals and objectives and describe any psychoeducational or service coordination strategies as they relate to other care providers and persons (other CMHRS services, Outpatient/Clinic Services, Foster Care, Judicial or Educational related staff, Relatives, etc.) who routinely come in contact with the individual.
- Service coordination or treatment planning meetings DO NOT have to be long intense meetings if members, families, and providers are working together collaboratively.

## Continuity of Care:

- All ISPs should clearly identify all current professionals involved in the member's care and in any necessary care coordination during the episode of care (i.e. educational, psychiatric, medical, case management, probation, etc.).

# *Person Centered Discharge Planning*

- Service plans shall incorporate an individualized discharge plan that describes transition from current services to other appropriate less intensive services. The discharge plan must summarize an estimated timetable to achieving the goals and objectives in the service plan and describe the methods that will be used to facilitate a successful transition to services. [CMHRS Manual Chap IV page 17-19]
- Ongoing consultation with the member and person-centered service planning team to reassess the member's changing strengths, preferences, functional levels, social and cognitive capabilities assures that the comprehensive needs of the member will be addressed at time of discharge.
- Active treatment and comprehensive discharge planning for aftercare placement and treatment must begin at admission. A lack of family or guardian involvement in discharge planning does not mean that discharge planning is not conducted. Discharge planning, at a minimum, should be an on-going discussion with the individual about managing symptoms, accessing and using resources, etc upon discharge. [Psychiatric Services Manual Chap IV page 15]
- Discharge planning starts on Day One of any service and incorporate how the member envisions discharge for them.

# *Person Centered Discharge Planning [cont.]*

- During discharge planning, members and families should receive verbal and written information on the range of services and available options that will be available in the member's community at time of discharge.
- Members and families should be given the opportunity to select the providers of services whenever possible.
- Referral mechanisms with community providers occur in a timely, systematic fashion in order for the member to gain access to identified resources. The process concludes with the coordination and implementation of services and transition to the least restrictive level of care in keeping with the member's needs and wishes.
- Recognizing that discharges shall be warranted when the service documentation does not demonstrate that services meet the service definition or when the services progress meets the “failed services” definition or when other less intensive services may achieve stabilization, discharge plans are expected to be specific to the needs of the individual at the time the service needs are reviewed.



# *Person Centered Service Planning: ISP as a living document*

**Reminder:** The Individual Service Plan is a “living” and “working” document. The Individual Service Plan is not meant to be a once and done document.

As interventions are completed, objectives are accomplished, and goals are achieved, the ISP needs to be updated to reflect current focuses and needs for the member. The Person Centered Individual Service Plan reflects the member where they are and changes as the member changes.

By adopting a person-centered approach to developing individual service plans, true collaborative partnerships can be established between providers and members allowing providers a more facilitative role and members a more decision making role in the service planning process. A far more effective approach.



*Questions?*



# Resources

Treatment Planning for Person-Centered Care, Second Edition: Shared Decision Making for Whole Health (Practical Resources for the Mental Health Professional) 2nd Edition by [Neal Adams](#) and [Diane M. Grieder](#) November 26, 2013

From Institutions to Individuals: on becoming person-centred October 5, 2012 by [Aaron Johannes](#)

A little book about Person Centered Planning by John O'Brien & Connie Lyle O'Brien.  
Nov. 1, 1998

[www.state.sc.us/dmh/ab/about/person\\_centered\\_poc](http://www.state.sc.us/dmh/ab/about/person_centered_poc)

<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>

<http://www.magellanofvirginia.com/for-providers-va.aspx>

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