

New York Association of Psychiatric Rehabilitation Services (NYAPRS) Person-Centered Planning Quality Indicators

As part of a broader effort in the State of New York, our agency is working striving 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/service/ recovery planning. Please use the below quality indicators checklist to evaluate the presence/absence of key Person-Centered Planning (PCP) documentation indicators.

Person-Centered Planning Indicators: Documentation Quality Review Tool			
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.		
B2	The plan/plan update actively incorporates the person’s identified strengths into the goals, objectives, or interventions.		
B3	<p>The narrative summary includes at least 4 of 6 of the following required elements:</p> <ol style="list-style-type: none"> 1. Strengths, interests, and current and/or desired life roles and priorities 2. Any interfering perpetuating factors, e.g., trauma history, co-occurring medical or substance use disorders, etc. 3. Individual’s stage of change 4. Available natural supports or community resources 5. Cultural factors and any impact on treatment 6. A clinical hypothesis/understanding/core theme re: what drives the individual’s experience of illness and recovery <p>Note: If all 6 items are not included, please note missing elements here:</p>		
B4	The goal statements on the plan/plan update are about having a meaningful life in the community, not only symptom reduction or compliance.		
B5	The plan/plan update includes 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” language (i.e., a <i>person living with schizophrenia</i> not a <i>schizophrenic</i>) and/or the individual’s name throughout the document.		
B7	The plan/plan update is developed collaboratively and there is evidence of direct input from the person, e.g., includes quotes from the individual and/or statements such as “Jose stated...”		
B8	There is evidence in the record that the person 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 objectives 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.		