Person-Centered Planning Indicators: Documentation Quality Review Tool

Documentation Indicator	yes	no
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, and recovery resources/assets.	☐	☐
The plan/plan update actively incorporates the person's identified strengths into the goals, objectives, or interventions.	☐	☐
The narrative summary includes at least 4 of 6 of the following required elements:		
• Strengths, interests, and current and/or desired life roles and priorities	☐	☐
• Any interfering perpetuating factors, (e.g., trauma history, co-occurring medical or substance use disorders).	☐	☐
• Individual's stage of change	☐	☐
• Available natural supports or community resources	☐	☐
• Cultural factors and any impact on treatment	☐	☐
• A clinical hypothesis/understanding/core theme about what drives the individual's experience of illness and recovery	☐	☐
Note: If all 6 items are not included, please note missing elements here:		
The goal statements on the plan/plan update are about having a meaningful life in the community, not only symptom reduction or compliance.	☐	☐
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.)	☐	☐
The plan/plan update uses "person-first" language (e.g., a "person living with schizophrenia" NOT a "schizophrenic") and/or the individual's name throughout the document.	☐	☐
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…")	☐	☐
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.)	☐	☐
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).	☐	☐
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.	☐	☐