



# *Effective Assessment and Service Planning: The Basics*

The Importance of Person Centered  
Assessment and Individual Service  
Planning

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# *Disclaimer*

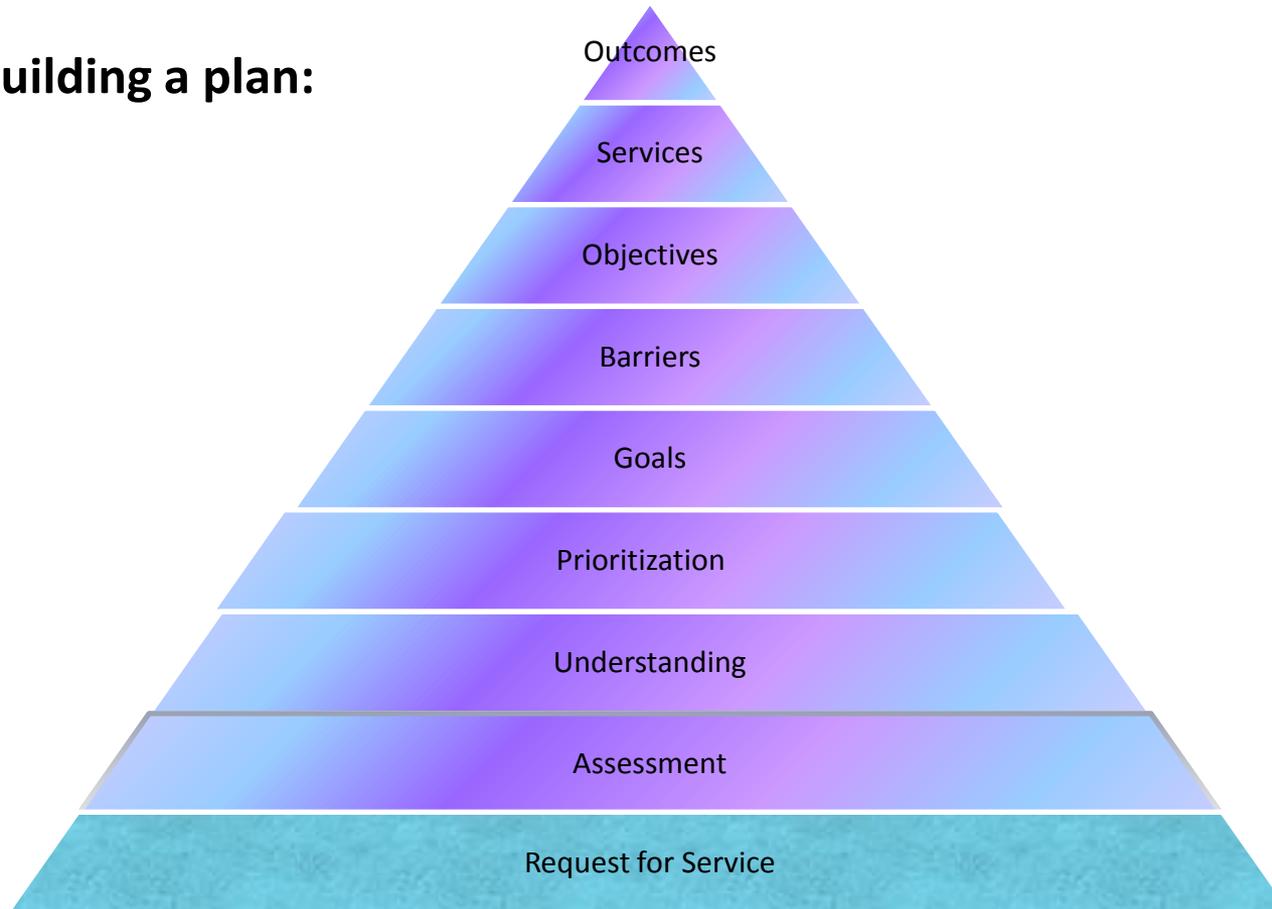
**This presentation is based on person centered planning information. It is not based on Virginia Department of Medical Assistance Services Regulations or the Virginia Department of Behavioral Health and Developmental Services Regulations. The information in this presentation does compliment the regulations of both departments.**

# *Learning Objectives*

- **The value of person centered planning.**
- **Use of assessment and individual service planning as an opportunity for engagement.**
- **Review of elements in a biopsychosocial assessment and individual service plan.**
- **Developing an individual service plan based on the assessment.**
- **The service plan as a living document.**
- **Documenting Progress**

# Person Centered Individual Service Planning

## Steps to building a plan:



***(Adams & Grieder, Treatment Planning for Person-Centered Care, 2005)***

# *Person Centered Planning: Why use it?*

**Too often assessment and service planning are not fully inclusive of the client/family. Helping professionals may 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 individual's preferences and goals.**
  - **Fostering dependency rather than self-reliance and recovery.**
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- **Why are these things a mistake? It invalidates the client's experience, 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 outcome for clients.**

# *Person Centered Planning: What is it?*

**It's an approach to assessment and service planning which:**

- **Emphasizes the uniqueness of each person and his/her right to self determination.**
- **Is based on principles of wellness, recovery, and hope.**
- **Seeks to discover strengths that each person/family possesses that will help them in their journey.**

# *Person Centered Planning: What is it?*

**When working from a person centered approach:**

- **Providers view the relationship with the individual/family as a partnership that supports the person's hopes, dreams and goals.**
- **The process is dynamic and changes based on the person's/family's wishes and needs, not on some predetermined outcome such as medication compliance, abstinence or "stability".**

# *Person Centered Planning: Engagement*



- **Person centered assessment and planning include the client/family as a team members. In fact, they are the most important team members.**
- **The person centered service plan is a shared vision between the client and the provider.**
- **The person centered helping professional thinks and speaks in strengths-based and recovery language.**
- **Provider and client work together to identify barriers and roadblocks to reaching goals. These are considered to be things standing in the way rather than as pathology.**

# *Person Centered Planning: Assessment*

**The assessment process can be viewed as a journey of discovery for both the provider and the member. The goal is to deepen and broaden the understanding of the person. A person centered approach to assessment:**

- **Meets clients/families where they are.**
- **Views the client/family as experts on themselves.**
- **Demonstrates a welcoming environment in which people are seen, heard, and respected.**
- **Values choice, self-determination, and empowerment.**
- **Begins by building on an individual/family's strengths, assets and areas of health and competence.**
- **Is holistic, fair and accurate.**

# *Person Centered Planning: Assessment*

**A person centered assessment is holistic and comes from a bio-psychosocial spiritual, strengths based model. Elements of a holistic assessment include domains from all major areas of life including:**

- **Presenting issues/reason for referral**
- **Strengths, resources, and supports**
- **Involvement in recovery**
- **Personal, Family, and Relationship history**
- **Work/Education history**
- **Mental Health History, current mental status and diagnosis (including what services and treatment have helped and what haven't)**
- **Physical Health**
- **Developmental History**
- **Legal involvement**
- **Substance use including tobacco**
- **Income, basic needs, and housing**
- **Barriers to reaching goals**
- **Case summary and formulation**

# *Person Centered Planning: Assessment*

## **The person centered assessment:**

- **is a picture of the client at the time the assessment is done.**
- **is not all there is to the client.**
- **is not static.**
- **is on-going throughout the time the client and provider work together.**

**The assessment information is used to develop an understanding of the client and her/his expressed wants and needs. It is an opportunity to build a respectful, collaborative partnership that is the foundation for a person centered service plan.**

# *Person Centered Planning: Individual Service Plan*



## **The Person Centered ISP:**

- **is based on the understanding of the individual gained during the assessment.**
- **is the road map for the work done by the client and provider.**
- **addresses the Strengths, Needs, Abilities, and Preferences of the individual.**
- **balances strengths with barriers.**
- **focuses on the client's life vision by incorporating his/her hopes, dreams, and goals.**

# *Person Centered Planning: Individual Service Plan*



**The Individual Service Plan includes the following elements:**

- **Statement of strengths, needs, abilities, and preferences leading to the goal.**
  - **Goals**
  - **Objectives**
  - **Interventions or Strategies**
  - **Target Dates**
  - **Status of each objective**
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- **Although every ISP includes the above elements, it should be individualized. If you are working with 10 clients and remove the name of the client from each ISP, you should be able to tell which client the ISP represents.**

# *Person Centered Planning: Individual Service Plan*



**Statement of Strengths, Needs, Abilities, and Preferences leading to the goal:**

**Example:**

**Jade has struggled with consistently taking medication prescribed for depression because of the belief she should be able to deal with her illness on her own. She has also experienced unpleasant side effects such as weight gain and stomach problems. Jade has been open about not wanting to take medication with her doctor and her case manager but understands she may need this intervention to get better since symptoms of depression interfere with her ability to work and have friends. She has experienced decreased symptoms of depression while she is taking medication.**

# *Person Centered Planning: Individual Service Plan*



**Person centered goals are:**

- **Long term, global and broadly stated**
- **Ideally expressed in the individual/family's words**
- **Easily understood**
- **Written in positive terms**
- **Realistic and attainable**

**Example of a person centered goal:**

**Jade wants to learn to manage symptoms related to depression in a way that allows her to work, socialize with friends, and maintain good health.**

# *Person Centered Planning: Individual Service Plan*



## **Person Centered Objectives are:**

- **Specific steps the client/family take to reach the goal**
- **Achievable**
- **Strengths based**
- **Measurable**
- **Action oriented**
- **Behavioral rather than process oriented**
- **Short term with a target date**

# *Person Centered Planning: Individual Service Plan*



- **Person Centered Interventions are:**
- **Steps the provider takes to help the member reach his or her goal**
- **Clear and measurable**
- **Identified for each objective**

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



- **The Individual Service Plan is not meant to be a once and done document.**
- **The ISP is a “living” or “working” document.**
- **It reflects the client where they are and changes as the client changes.**
- **As objectives are accomplished, the ISP is updated to reflect the current focus of the client. Objectives may be resolved or added.**
- **The principals and guidelines reviewed earlier in the presentation apply to the ISP review process with the client and family.**

# *Person Centered Planning: Documenting progress*

Progress Notes should reflect the work being done by the client and the provider as outlined in the ISP.

Progress notes may be formatted in many different ways.

Two examples for formats are:

- SOAP Notes:**
- Subjective Data** (Statements client makes about problem or course of treatment)
  - Objective Data** (Gathered by observation of client's actions or behaviors)
  - Assessment** (Based on the Subjective and Objective Data collected)
  - Plan** (Based on A, updates Service Plan)
- BIRP Notes:**
- Behavior** (Provider observation, client statements)
  - Intervention** (Provider's methods used to address goals and objectives, observations, client statements)
  - Response** (Client's response to the intervention, progress made toward Tx Plan goals and objectives)
  - Plan** (Document what is going to happen next)

# *Person Centered Planning: Documentation Map*

Each step of the planning process informs the next. The documentation should accurately reflect this process.



The documentation should be individualized and reflect the unique picture of the client and the collaborative work being done between client and provider.

*Questions?*



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