Issue Brief

Person-Centered Planning

Introduction

Following decades of calls for person-centered approaches to health and recovery from community groups, the landmark 2003 President's New Freedom Commission on Mental Health identified person-centered planning (PCP) as an essential practice that should be "at the core of the consumer-centered, recovery-oriented mental health system."[1] SAMHSA's 10 Guiding Principles of Recovery echo the call for "person-driven" systems where people optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports with which they engage.[2]

This philosophical commitment to person-centeredness in behavioral health services—and in long-term services and supports for all populations—subsequently evolved into national quality expectations through a series of legislative and regulatory actions that made clear the mandate to provide person-centered care and planning. These include expectations outlined in the Community Mental Health Services Block Grant (MHBG) Program,[3] Certified Community Behavioral Health Clinic (CCBHC) criteria,[4] and Section 2402(a) of the Affordable Care Act[5]—Guidance for Implementing Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs.

About This SERIES

The Substance Abuse and Mental Health Services Administration (SAMHSA) developed this series to provide guidance to states related to critical issues that may be addressed by the Community Mental Health Services Block Grant (MHBG).

This issue brief provides information for State Mental Health Authorities (SMHA) about strategies for promoting person-centered planning (PCP) to enhance the quality of behavioral health services and the valued recovery outcomes of those that use them.

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There are a variety of ways that State Mental Health Authorities (SMHAs) can incorporate person-centered principles and practices into planning and guidance related to behavioral health services at the local level, and a multitude of resources that SMHAs can use to support these changes.

What is Person-Centered Planning?

> **Person-centered planning (PCP) is a way to learn about the choices and interests that make up a person's idea of a good life—and to identify the supports (paid and unpaid) needed to achieve that life.**
>
> **—National Center on Advancing Person-Centered Practices and Systems**

Person-centered planning (PCP) is a process led by the person receiving support in collaboration with chosen team members (paid and unpaid) that results in the co-creation of an action plan centered around the individual's most valued priorities and wellness goals.[6] A central tenet of PCP is that people are experts in their own lives, and through a partnership based on trust, empathy, and collaboration, the process of planning will ultimately increase a person's sense of autonomy and ownership over their well-being. A full definition of PCP, developed by a committee of experts with lived and professional experience, is outlined in the 2020 Person-Centered Planning and Practice Final Report from the National Quality Forum. Additional information is available from The National Center on Advancing Person-Centered Practices and Systems (NCAPPS), a national clearinghouse of tools and approaches for promoting PCP within long-term service and support systems, including behavioral health systems.

Why Promote PCP in Your State?

The values that underpin PCP—equitable access to quality supports, community inclusion, and self-determination—are widely espoused by United States healthcare and long-term service and support service systems.[7; 8] As noted above, these values are operationalized as requirements by state and federal regulators. An emerging evidence base shows PCP's positive impact on a range of outcomes including improvements in physical and mental health, quality of life, self-management and involvement in care planning, familial and social supports, and sense of control and self-efficacy.[9-14]

> **Even the most competent and committed PCP practitioners will not be able to fully actualize their competency in practice in the absence of systems characteristics that align in support of person-centered planning.[15]**

Despite a growing endorsement of PCP, people with mental health and substance use concerns often experience service planning as oriented to the requirements of bureaucracies rather than to the goal of providing real and meaningful opportunities for choice and self-determination.[16] A range of complex implementation barriers—from the philosophical to the practical—contribute to this problem.[17; 18] Paramount among these barriers is inadequate attention to critical systemic practices necessary to support the robust implementation of PCP in state behavioral health systems. Ultimately, PCP is only effective when it takes place in person-centered systems.

Because of the system-level importance of PCP implementation, we present information below organized by the 8 dimensions of person-centered systems identified in the [Person-Centered Practices Self-Assessment](). The tool was designed by NCAPPS to help state-level leadership to both guide and gauge their progress in developing a more person-centered system.[19]

Leadership

The leadership dimension of person-centered systems involves the extent to which state leaders understand and embrace PCP principles. Leaders embed PCP principles in all functional, program, and policy areas, and ensure they are reflected in state agency mission, vision, and guiding principles. This includes aligning PCP best practice with service planning standards as outlined in state administrative code.

Developing a state- or agency-specific, clearly stated definition of PCP can be a critical first step in demonstrating an organization's commitment to PCP. Examples of such definitions can be found in [Person-Centered Thinking, Planning, and Practice: Representative Examples of State Definitions](). Both the content of the definition, as well as the participatory process behind its development, should be thoughtfully designed.

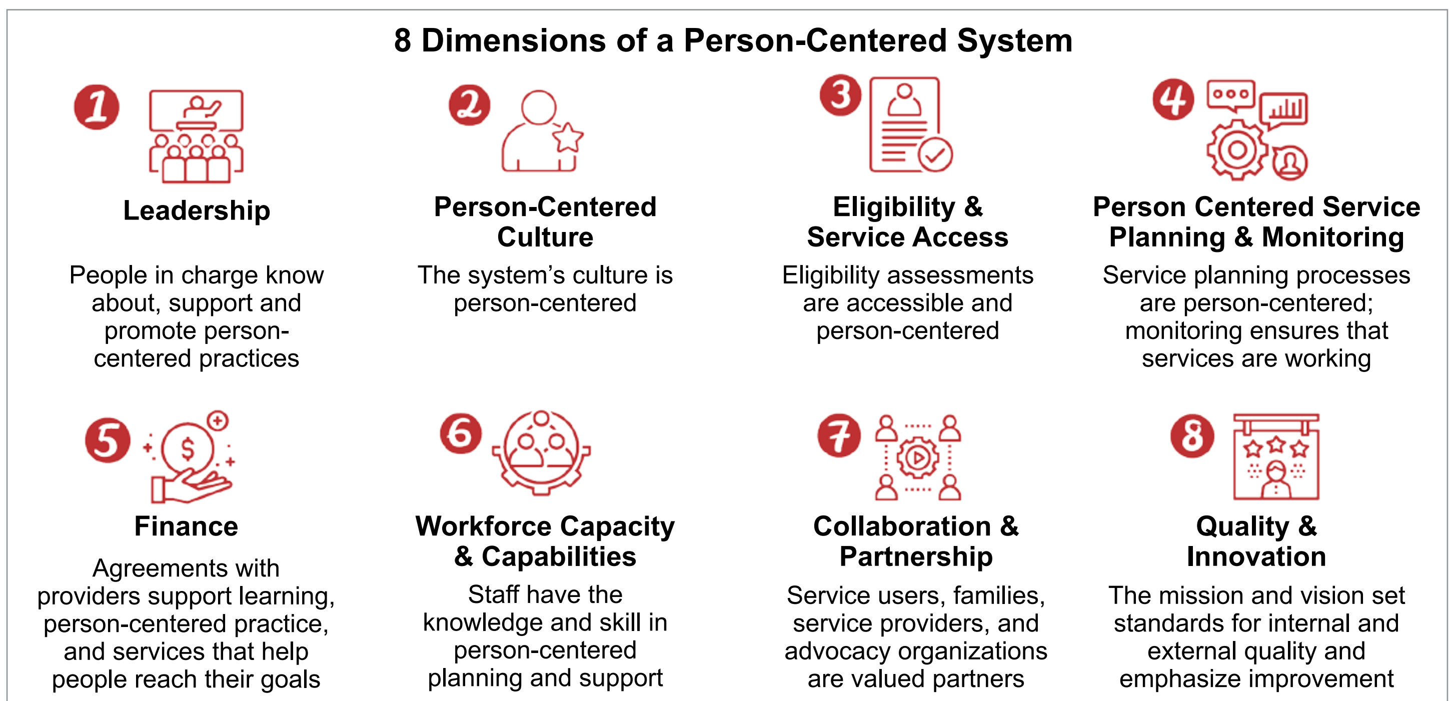

Figure 1: NCAPPS Person-Centered Practices Self-Assessment

Source: Bourne, Mary Lou (2022). NCAPPS Person-Centered Practices Self-Assessment. National Association of State Directors of Developmental Disabilities Services, Management Support Solutions, Inc., and Human Services Research Institute. Cambridge, MA: National Center on Advancing Person-Centered Practices and Systems.

A state's PCP definition should subsequently inform efforts to develop more comprehensive resources to support PCP implementation such as [Connecticut's Recovery-Oriented Practice Guidelines] and [North Carolina's Person-Centered Planning Guidance Document]. The promotion of PCP definitions and resources is part of a larger communication plan that is transparent, culturally responsive, accessible, and user-friendly. Messaging is tailored to be responsive to the needs of unique stakeholder audiences. For example, when developing materials about PCP that are intended for people and their natural supporters, states can create parallel versions that are easy to read to increase accessibility of the documents and highlight the most critical information needed and desired from the unique perspective of service users. The best and only way to ensure PCP materials are accessible and responsive is to develop them in partnership *with* people themselves.

State leaders also appreciate that behavioral health services are a vital, yet often insufficient, avenue for supporting people in the pursuit of desired life goals. Valued participation in society requires reaching beyond the boundaries of formal treatment systems to support the "whole person" in the context of their chosen community. To facilitate this approach and maximize connections in community settings wherever possible, leadership intentionally build alliances supportive of the PCP process with other systems including criminal, legal, education, healthcare, housing, employment, faith-based, and social service agencies.

Person-Centered Culture

An organizational culture rooted in person-centered values is a prerequisite for PCP implementation. Those who work within the system must believe that people can, and do, recover; believe that people can, and should, self-determine to the maximum extent possible; and believe that a meaningful, self-directed life in the community is a fundamental right for all people no matter their disability.

These fundamental assumptions should be evident in all agency oversight meetings, utilization reviews, monitoring procedures, trainings, and communications. SMHAs can foster person-centered culture and create a sense of urgency around organizational change by widely sharing personal narratives and testimony from people in services about how they may have felt disempowered or invalidated in the service planning process. These narratives may also include powerful stories regarding their experiences with stigma and discrimination.[20] State leaders should acknowledge the harm done by involuntary and coercive approaches and consistently prioritize voluntary, trauma-informed alternatives and harm reduction approaches. Within the PCP and service delivery processes, leaders should partner with providers to develop policies and guidance to balance dignity of risk with health and safety, and to ensure a person demonstrates an informed understanding of their choices to participate in the behavioral health system.

> **It is important to offer a diverse array of treatment options to individuals undergoing court-mandated, involuntary treatment. This approach not only respects their autonomy, but may enhance the effectiveness of treatment and lead to better outcomes.**

Similarly, person-centered system leaders acknowledge and respond to the interface between PCP and the organization's diversity, equity, justice, and inclusion efforts. Even treatment systems that strive to be recovery-oriented and person-centered are challenged by staggering disparities in access to care, health and recovery outcomes, and the use of involuntary and restrictive treatment interventions.[21-23] In this sense, those who are marginalized based upon their race, sexual orientation, gender identity, national origin, disability status and other statuses often experience—individually and collectively—an additional layer of trauma, both inside and outside behavioral health

settings. It is impossible to fully realize the promise of PCP in a system that is not also committed to the achievement of equity in the accessibility and delivery of behavioral health services.

Eligibility and Service Access

From the person's perspective, initial interactions with the system at the "front door" set the tone for engagement over the long-term. Eligibility determination processes, professional assessments, and subsequent referrals should therefore be oriented toward equitable access, understanding the person in the context of their social environment and culture, and accounting for strengths and preferences alongside challenges and service needs.

Most systems use standardized assessment processes for determining initial service eligibility and assigning levels of care. Often these processes are focused on documenting clinical and functional need and do not include a full consideration of the person's strengths, preferences, and desired life goals. Further, eligibility and assessment processes are typically completed by designated personnel within program models that do not allow for the time, opportunity, or kind of relationship necessary to conduct person-centered assessment.

Initial assessment processes should be designed to make space for exploration of the person's most valued goals in life since these goals serve as the source of the person's motivation and the foundation of a quality person-centered plan. Such exploration and goal discovery should be incorporated as integral parts of determining eligibility and are necessary to make appropriate service referrals. It is impossible to fully understand what a person *needs unless you start with what they want.*[24]

To move toward more person-centered eligibility and access procedures, "front door" business practices and workflow may need to be revisited with a focus on optimizing both efficiency and person-centered

design. Specific strategies include systematically cross-checking the multiple assessments that are carried out by multiple practitioners during the intake process—a process that often reveals significant internal redundancies in areas of inquiry. These redundancies reflect inefficient use of agency resources and are often experienced by service users as intrusive and unnecessary.

In addition to evaluating what is being asked, person-centered systems also consider who is doing the asking. Specifically, involving peer supporters in initial orientation and intake procedures is a strategy to help share the responsibility for person-centered assessment among different types of agency staff. This reduces burden on staff whose functions are, by necessity, more focused on screening for eligibility. It also helps ensure critical information for PCP is solicited from the very first point of contact. Eliminating internal redundancies and engaging additional staff to facilitate person-centered assessment promotes efficient use of limited resources while enhancing the service user's experience.

Finally, given persistent disparities across behavioral health systems,[21-23] steps to ensure equity in access are widely considered best practice and a hallmark of person-centered systems. The National Standards for Culturally and Linguistically Appropriate Services (CLAS) are in full alignment with the characteristics of a person-centered system described in this brief. Strategies to include equity in access include:

- Using demographic data to identify underserved population groups.
- Engaging with community leaders from under-served groups to learn how to better reach and serve them.
- Working to ensure the "front door" workforce is representative of the community in terms of race, culture, disability identity, and other characteristics.
- Creating informational materials that are responsive to the populations served. This includes translating materials into commonly spoken languages, using images and symbols that reflect the racial and cultural diversity of the community, and ensuring that all materials meet Americans with Disability Act (ADA) requirements.
- Using multiple avenues for communication based on community preferences, including social media platforms, texting, print materials, and other channels.

Person-Centered Service Planning and Monitoring

> Consumers demand it, public service systems endorse it, medical and professional programs are encouraged to teach it, and researchers investigate it.
>
> Yet, people struggle to understand exactly what "it" is and what "it" might look like in practice.[25]

> Providers express feelings of tension between personal investment in their work—which is often aligned with the principles of person-centered care—and the more bureaucratic demands of their work. This includes, but is not limited to, the perpetuation of electronic health records with poorly designed templates that remain rooted in traditional, problem-focused approaches to care planning.[26]

Despite federal and regulatory expectations for PCP, there is continued confusion across the country regarding the translation of person-centered principles into concrete practice guidelines. In the absence of these guidelines, systems and the practitioners within them tend to default to the assumption that "we already do PCP," leaving people who receive services disillusioned when their experience suggests otherwise.[18] To more robustly implement PCP and align policies,

procedures, and programs in accordance with federal regulations, states can refer to tools and resources specific to the application of PCP in behavioral health systems.[18] One example is the *Recovery Roadmap*, developed by the Yale Program for Recovery and Community Health in partnership with C4 Innovations. Two versions of materials—one oriented toward staff and the other for service users—work together to build skills and confidence across both sides of the partnership. The *Recovery Roadmap includes a series of tip sheets that present user-friendly quality indicators* designed to demystify both the process and documentation of PCP. Tips for Recognizing Good Person-Centered Process is a 25-item tool that provides straightforward descriptions of concrete actions that should be taken in any 1:1 or team-based PCP meeting. Tips for Recognizing a Good PCP is a 21-item plan review tool that guides users in assessing whether plan documentation reflects specific person-centered principles and practices.

While tools such as the *Recovery Roadmap* can help shape the quality of PCP and the integrity with which it is implemented, it is also critical to evaluate whether higher quality implementation actually results in meaningful person-centered outcomes for the people it is intended to benefit. Further information on quality monitoring of person-centered outcomes is included in the Quality and Innovation systems dimension.

Notably, the tools and templates practitioners must use to document PCP can present as major obstacles to quality. For example, rigid technical structures in electronic health records (EHRs) with an overreliance on drop-down menus and auto-population of data fields limit the ability to include important individualized detail, such as incorporating personal life goals into the plan.[27] Such EHRs typically generate "cookie-cutter" plans that are highly deficit-based and experienced as unhelpful, or even offensive, by the very people the plans are intended to serve.

While changes to EHR platforms are not always necessary in PCP implementation, it is advantageous to align the EHR with the person-centered practices you are seeking to maximize. For example, electronic platforms have the potential to accelerate information sharing among the person and their care team, including the immediate access to visit notes and treatment plans that is now possible with the advent of online patient portals. While concerns have been noted around negative consequences of service users having such open access to their records,[29] people have a legal right to view their treatment records without undue interference. This type of transparency is considered a hallmark of recovery-oriented behavioral health systems and is a standard expectation in shared decision-making in all forms of American healthcare.

An organization's desire to maximize person-centered features in EHR design should be explicit in front end negotiations as organizations evaluate and select vendors. It is also wise to explore what is involved in the ongoing modification process so that the EHR can be tailored over time in response to feedback, including feedback from people who use services. SMHAs can support providers in implementing their PCP skills by developing state-level EHRs that attend to these considerations or by providing financial incentives to health systems committed to enhancing or upgrading their EHR platforms.

SMHAs and other organizations looking for practical guidance on the development of EHR platforms that facilitate the uptake of PCP should refer to The Promise and Pitfalls of Electronic Health Records and Person-Centered Care Planning. This resource provides specific recommendations across a variety of EHR design elements in the hope that thoughtful EHR design can do more than "get out of the way" of PCP but become a vital strategy in promoting person-centered care as a whole across state behavioral health systems.

Transparency in Electronic Records

OpenNotes is an international initiative designed to encourage healthcare systems to provide greater transparency in care. The initiative disseminates information on best practices for communicating health information to individuals and care partners, through open access to notes on patient portals.

The Veterans Health Administration allowed online access to medical notes in 2013 on their online portal, My HealtheVet. Mental health clinicians were offered a web-based course on OpenNotes, addressing provider concerns, best practices on writing for the patient audience, how to incorporate individual strengths and a focus on recovery, and communicating with patients about difficult topics, amongst other topics.

Wider dissemination or development of similar training courses may help to reduce worry over negative consequences of sharing notes and improve patient and care team communications.[28]

Finance

Person-centered systems embed requirements around PCP throughout their fiscal and administrative infrastructure. SMHAs can reflect this practice by developing provider agreements requiring PCP for all people receiving services, training in person-centered principles for all staff, and ongoing performance measurement and reporting around person-centered expectations. Person-centered systems also require performance improvement activities for any consistently unacceptable performance of these contract requirements. In the context of financing, value should be determined by how well services are helping people to attain their most valued goals.

System-wide policy requires that service planning and service authorization align and demonstrate person-centered values (i.e., dynamic, responsive, and flexible). There is an expectation of accountability to modify the PCP and accompanying services if people have been unable to progress over time or if their priority goals have shifted and other services are needed to better support them. Processes for modification help ensure that services lead to personal goals and objectives, can change as needed, do not hold a person back from taking new opportunities, and are accomplished in a timely fashion. This is commonly referred to as treating the plan as a “living document” that changes flexibly in response to changes in a person’s preferences and needs.

In addition to embedding PCP requirements in contracts and performance management expectations, state leaders can also align financial incentives to better enable providers to dedicate time to partner with the people they serve to co-create quality PCPs. In many states, assessment and planning are not currently recognized by payers as specific practices for which provider agencies can seek reimbursement.[30] Rather, time spent on assessment and planning is rolled into an overall reimbursement rate. In this model there is little incentive to enhance planning processes and documentation in alignment with PCP. This highlights a larger systemic issue of whether federal and state behavioral health payers appreciate PCP as a valuable intervention unto itself and designate it as a billable service worthy of reimbursement. Despite this dilemma, promising practices to

support PCP implementation can be found within both existing and emerging service structures and financing models:

- At the federal level, per published CCBHC criteria, the delivery of services must be "based on a person and family-centered plan of care aligned with the requirements of Section 2402(a) of the ACA." In return for providing an enhanced service package and expanded person-centered care coordination, CCBHCs receive an enhanced Medicaid reimbursement rate. In this sense, the emergence of the CCBHC service delivery model has been an external factor which has positively incentivized organizational commitment to PCP implementation.
- At the state level, New York's Personalized Recovery Oriented Services (PROS) program recognizes Individualized Recovery Planning as within the menu of allowable interventions that practitioners can offer. Practitioners are able to count the time dedicated to planning as a part of what they are paid to carry out with PROS participants. This reinforces the value of the PCP plan as being more than just a paper document to satisfy the chart, and it removes a significant disincentive to collaborative planning efforts that exists when the collaborative task/time is not covered as a reimbursable service.

Even in circumstances where PCP is not formally recognized as a billable intervention, organizations demonstrate person-centered leadership by developing methods for tracking staff time in activities that can be "counted" toward staff productivity. Allowing staff to receive "credit" for both professional development and non-billable PCP activities carried out with people receiving services sends the message that the organization values PCP as an essential practice by helping to address a common implementation barrier.

Workforce Capacity and Capabilities

Developing workforce capacity and capabilities is a critical system-wide strategy for promoting PCP. States can develop and/or promote existing resource guides and trainings for staff in multiple roles. For example, research suggests that PCP training of supervisors in community mental health clinics helps providers make a philosophical shift in support of PCP, while also enhancing their technical skill set to implement PCPs.[31] While clinical staff are one critical target in building workforce capacity, all staff should have a demonstrated degree of PCP competence, with some variation based on unique roles. For example, peer support specialists may be particularly well-suited to lead efforts around building self-advocacy skills and supporting self-determination.

It is essential that system leadership go beyond the rhetoric and all-too-often hollow promises of person-centered philosophy to invest in developing workforce capacity around a clearly articulated set of knowledge, skills, and abilities that collectively represent PCP in action. The Five Competency Domains for Staff Who Facilitate Person-Centered Planning details areas of competency necessary to effectively facilitate PCP. The 5 Competency Domains were developed through reviewing 16 national sources that outline essential skills, practicestandards, federal regulations, and learning objectives for person-centered thinking, planning, and practice from a range of fields and disability service populations. SMHAs can use this resource to crosswalk the competency domains with existing state PCP training curricula to ensure they are adequately addressed through educational content, experiential exercises, and the provision of person-centered tools and resources. Along with quality indicators mapping out essential practices in person-centered process and documentation, the 5 Competency Domains should directly inform a wide

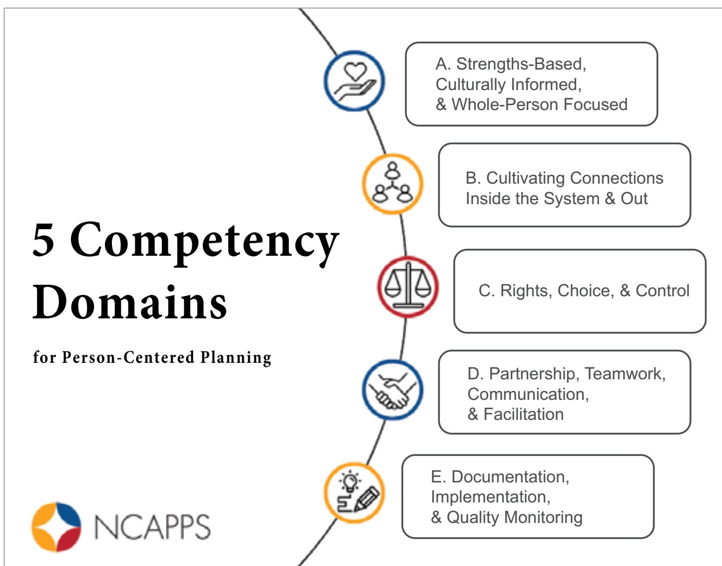

Figure 2: Five Competency Domains for Staff Who Facilitate Person-Centered Planning.

Source: Tondora, J., Croft, B., Kardell, Y., Camacho-Gonsalves, T., and Kwak, M. (2020). Five Competency Domains for Staff Who Facilitate Person-Centered Planning. Cambridge, MA: National Center on Advancing Person-Centered Practices and Systems.

range of human resources policies and procedures. This includes actively building PCP knowledge, skills, and abilities into job descriptions, recruitment and hiring decisions, interview questions, ongoing performance evaluation, supervision and professional development plans, and advancement and promotion criteria.

Finally, SMHA leadership responsible for building workforce capacity in PCP should be mindful of not only *what* is being taught in training, but *how* it is being taught. Training initiatives in behavioral health tend to rely on outdated and ineffective models of didactic presentation and rarely employ evidence-based implementation strategies.[32] Proven methods include experiential/interactive training, onsite technical assistance with continuous feedback, the identification and use of internal agency "champions" to promote change, active involvement of people with lived experience in the design and delivery of training, and clinical supervision and strengths-based coaching in day-to-day work. The state of Texas supports a particularly robust model of building PCP workforce capacity through the work of the Person-Centered Recovery Planning Initiative of the Via Hope Recovery Institute.

Collaboration and Partnership

- Research has demonstrated that the single most impactful intervention to enhance an organization's recovery orientation is the active and direct involvement of people with lived experience in all aspects of systems change, including the design, delivery, and evaluation of services.[33] People who use services and their family/chosen family and other "natural" or unpaid supporters are essential partners in a person-centered system. Trusting and supportive relationships with service provider partners are also essential, as providers have unique viewpoints on systemic factors that promote and inhibit successful PCP. Finally, advocates in peer-run organizations and family groups can provide critical input on system performance to help ensure the system has the resources it needs to function in a person-centered way. Authentic engagement results in innovative ideas for improvement, pressure for positive change, and accountability to the SMHA's person-centered mission, vision, and values.

- Successful and equitable engagement at the systems level requires skill and commitment from state leaders. There are different resources that can maximize the involvement of critical stakeholder groups in PCP initiatives. The Toolkit for Stakeholder Asset Mapping outlines steps to inventory and engage various community groups to engage in ongoing system improvement efforts. This process can save organizational time and resources while building trust with communities served. Engaging People Who Receive Services: A Best Practice Guide includes specific strategies to support people to participate more fully and take leadership roles in systems change and advisory groups and councils. Person-centered leaders recognize that

the "invitation to the table" is not enough and systems-level participatory engagement efforts should start with the understanding that the table should belong to people with lived experience.

Another aspect of engagement and partnership involves ensuring that people who use services have the necessary skills, information, and confidence to engage in the PCP process at the individual level. Resources such as Getting in the Driver's Seat of Your Treatment can aid in this process. This toolkit was developed with people in recovery for people in recovery to assist them in assuming their desired level of involvement in person centered planning. Educating and orienting people so they feel more confident in the "driver's seat" of the planning process is a task that can be carried out by any staff member who is knowledgeable about and committed to the principles and practices of PCP. One particularly effective strategy in preparing people to partner is to offer them the support of peer specialists who can provide coaching throughout the planning process.[34] This strategy is consistent with ongoing efforts of SMHAs to ensure that people with lived experience of using mental health and substance use services have a diversity of paid roles within behavioral health systems. Hiring people with lived experience, specifically peer professionals, is a potent strategy for creating an organizational culture within which PCP can thrive.

The centrality of partnership with people with lived experience in all aspects of PCP implementation is not intended to minimize the importance of engaging other critical groups, including direct service practitioners. PCP is best implemented alongside parallel structures that support staff to maintain their personal wellness, feel empowered in their professional roles, and reach their full potential as agents of person-centered change. Unfortunately, direct service practitioners tend to be on the periphery of PCP change efforts, despite often being in the best position to identify organizational barriers and facilitators. To tap into this institutional knowledge and demonstrate inclusivity, systems leaders should actively elicit staff feedback about their implementation needs early on, act on the most common needs indicated by staff, and communicate their actions widely at the organizational level.

Quality and Innovation

Robust quality improvement practices are essential for person-centered systems. Ideally, a SMHA's mission, vision, and values are directly connected to measurable standards that are used to monitor and continuously improve PCP and other characteristics of person-centered systems. Progress toward improvement should be routinely shared with the community—including people who use services and providers—who are engaged as partners to identify areas for improvement and hold the system accountable to its mission, vision, and values.

Quality improvement metrics should include system performance information, experience measures, and person-centered outcomes. Examples of person-centered indicators can be found in the resource Person-Centered Thinking, Planning, and Practice: A National Environmental Scan of Indicators. As highlighted earlier, the National Quality Forum offers a useful organizing framework for quality measures, specifying measurement at the levels of the PCP (How person-centered is the plan itself?), the PCP facilitator (To what extent are PCP competencies demonstrated?), and the system (To what extent are organizational variables aligned with person-centered principles?)

Specific examples of PCP measurement tools across these levels can be found in aspects of the widely used Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey, which is part of the Adult Consumer Survey Toolkit; the NCAPPS resource Person-Centered Thinking, Planning, and Practice: A National Environmental Scan of Indicators, and a 2014 evidence review[35] that describes multiple options for measuring person-centered care. The NCAPPS resource

referenced in the introduction of this brief, the Person-Centered Practices Self-Assessment, may be of particular interest to SMHA leadership given its focus on systems-level indicators to facilitate statewide implementation of quality person-centered practices. At the level of the service plan, the Person-Centered Care Planning Assessment Measure (PCCP-AM) is an objective measure of the extent to which planning is person-centered based on a review of key indicators found in the PCP document itself. While these efforts to develop targeted and reliable chart review tools add to the overall landscape of PCP measurement, they can be cumbersome to implement in practice and more importantly, they should not be taken as a proxy for the person's experience.

States can use *The Recovery Roadmap Tips for Recognizing Person-Centered Process: Was My Planning Meeting Carried Out in a Person-Centered Way?* and *Tips for Recognizing a Good Person-Centered Plan: Is My Planning Document Person-Centered?* to assess process changes in PCP implementation from people receiving services while also educating them on what they can and should expect in quality planning and documentation.

This highlights the need for systems leaders to think about not only the various levels of PCP measurement, but also the sources of the data that measurement relies on. Implementation and evaluation efforts tend to focus heavily on the quality of PCP documentation given the relative feasibility of extracting indicators from chart reviews. While the written plan provides one source of data to monitor quality, the quality of the plan on paper (or in the EHR) is meaningless unless it is authentically founded on a quality person-centered process. For this reason, in addition to plan reviews, monitoring in PCP implementation should include observational audits of 1:1 or group-based planning meetings to ensure that they are being facilitated in accordance with person-centered principles. Finally, perhaps most essential to systemic accountability around PCP is the routine solicitation of direct feedback from people with lived experience through diverse methods of data collection including individual surveys, focus groups, and ongoing input from peer-based advocacy organizations.

Summary

Given philosophical and regulatory imperatives around the central importance of PCP in all behavioral health services, SMHAs must have a full understanding of how PCP is defined, why it is important, and how to facilitate its implementation with state-level organizational strategies. This Issue Brief provides a review of these strategies and presents tools and resources to support PCP as it exists in its current form, but also as it has the potential to look in ideal practice. It is hoped that transformational leaders will use these tools and resources to move toward this ideal, in both word and in action, to more fully honor the spirit and standards of quality PCP.

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