Person-Centered Service Plans and Treatment Plans

What they are, how they work together, and who is responsible

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Learning Objectives

By the end of this presentation, participants will be able to:

01 Define the Person-Centered Service Plan (PCSP)

02 Define a Treatment Plan / Plan of Care

03 Explain how PCSPs and Treatment Plans differ

04 Identify responsibilities of PASSEs, care coordinators, providers, members, and guardians

05 Describe communication and coordination expectations

06 Connect quality measures to outcomes

Why This Matters

Clear roles support timely, coordinated, person-centered care.

The PASSE model depends on

- Person-centered planning
- Care coordination
- Shared accountability
- Effective communication
- Measurable outcomes

Role confusion can result in:

- Delayed services
- Gaps in care
- Incorrect expectations
- Authorization delays
- Poor member outcomes

What is a Person-Centered Service Plan (PCSP)?

The PCSP is the roadmap for helping a member live safely and successfully in the community.

What it is

- A comprehensive planning document
- Based on assessments and identified needs
- Developed through a person-centered process

What it focuses on

- Goals and desired outcomes
- Preferences and strengths
- Support needs and coordination

What it organizes

- Paid supports
- Unpaid supports
- Risk mitigation
- Safety and crisis planning

Required Elements of the PCSP

As required under federal and PASSE requirements, a PCSP must include the following elements:

1 Member profile

- Health information
- Medical and behavioral diagnoses
- Strengths and preferences
- Goals and desired outcomes

2 Services and supports

- Support needs
- Paid supports
- Unpaid supports

3 Safety and planning

- Risk mitigation planning
- Safety and crisis planning

The PCSP brings together whole-person information, services, supports, and safeguards in one coordinated plan.

What is a Treatment Plan?

As required under federal and PASSE requirements, a PCSP must include the following elements:

1. **Is a clinical document**
2. **Is developed by treating providers**
3. **Is based on diagnosis and clinical assessment**
4. **Guides treatment interventions**
5. **Documents medical necessity**

Examples include: Behavioral Health Treatment Plans, Nursing Plans of Care, Occupational Therapy Plans of Care, Physical Therapy Plans of Care

PCSP vs Treatment Plan

Different purposes. One coordinated direction.

	PCSP	TREATMENT PLAN
Focus	Whole person	Clinical
Foundation	Goals and preferences	Diagnosis
Development	Person-centered planning	Clinical assessment
Purpose	Coordinates all services	Guides treatment delivery
Ownership	Created and maintained by PASSE	Created by provider
Contents	Paid and unpaid supports	Interventions and therapies

PCSP and Treatment Plans Work Together

Both are necessary. Neither replaces the other.

PCSP answers:

“What does the member want to achieve?”

Treatment Plan answers:

“How will services help achieve those goals?”

The documents should complement one another.

Who Owns What?

Clear ownership supports coordinated planning, clinical care, authorizations, and outcomes.

Function	Responsible Party
Goal Setting	Member/Guardian
PCSP Development	PASSE
PCSP Monitoring	PASSE
Care Coordination	PASSE
Clinical Assessment	Provider
Diagnosis	Provider
Treatment Plan	Provider
Authorization Decisions	Utilization Management
Outcomes	Shared Responsibility

Role of the Member vs Parent/Guardian

The member's goals, preferences, choices, and changing needs anchor the process.

Member responsibilities

- Direct the planning process
- Identify goals
- Express preferences
- Participate in meetings
- Request changes when needs change
- Choose who participates

Parent and guardian responsibilities

- Participate in planning
- Advocate for needs
- Help identify risks
- Assist with decision-making
- Monitor progress
- Share information about changing needs

Foundational Principle | Planning is done with the member, not for the member.

Role of the PASSE

The member's goals, preferences, choices, and changing needs anchor the process.

Member responsibilities

- Direct the planning process
- Identify goals
- Express preferences
- Participate in meetings
- Request changes when needs change
- Choose who participates

Parent and guardian responsibilities

- Participate in planning
- Advocate for needs
- Help identify risks
- Assist with decision-making
- Monitor progress
- Share information about changing needs

Role of the PASSE

The PASSE owns PCSP creation, monitoring, updating, and system-level care coordination.

01 Create and update

Develop and maintain the PCSP.

02 Coordinate care

Connect providers, settings, and supports.

03 Ensure access

Address barriers to covered services.

04 Manage the network

Maintain an adequate provider network.

05 Monitor quality

Track performance and member outcomes.

06 Support authorization

Facilitate complete, timely service requests.

Role of the Care Coordinator

The Care Coordinator is the primary PASSE contact, but clinical functions remain with providers.

CORE RESPONSIBILITIES

01 Is the primary PASSE contact

02 Review assessments

03 Coordinate providers

04 Facilitate PCSP development

05 Schedule PCSP meetings

06 Monitor progress

07 Assist during transitions

CLEAR BOUNDARIES

- ✗ Does not diagnose
- ✗ Does not prescribe treatment
- ✗ Does not determine medical necessity
- ✗ Does not approve services
- ✗ Does not create treatment plans

Providers and Utilization Management Have Distinct Roles

The PCSP identifies needed services; it does not automatically authorize those services.

PROVIDER

Owns treatment planning

- Assessment
- Diagnosis
- Treatment planning
- Service delivery
- Progress monitoring
- Clinical recommendations
- Communication of significant changes

UTILIZATION MANAGEMENT

Owns authorization decisions

- Review service requests
- Conduct medical necessity review
- Issue approvals
- Issue denials
- Ensure regulatory compliance

Communication Turns Separate Responsibilities into Coordinated Care

Effective coordination requires timely, bidirectional information flow and shared problem solving.



When the PCSP Must be Updated

Annual updates are required at minimum, and updates are also required when needs or circumstances change.



Significant Changes Require Coordinated Action

Examples include:

01 Hospitalization or ER visit

02 Crisis stabilization

03 New diagnosis or medication change

04 Residential admission or discharge

05 Guardian or school change

06 DCFS involvement

Risk Mitigation and Safety Planning

Risk mitigation is a required component of PCSP.

01 Health and safety concerns

02 Environmental risks

03 Behavioral risks

04 Supervision needs

05 Prevention strategies

06 Support systems

Risk planning should address prevention, supervision, support systems, and crisis response.

Quality is Measured Through Outcomes

The focus is not simply whether services were delivered, but whether services improved the member's life. Success is measured by:

- **Goal achievement**
- Community integration
- Member satisfaction
- Improved health
- Reduced crises
- Reduced institutional stays
- Increased independence

Examples of PASSE Quality Metrics

Examples of DHS measures include:

01 **PCSP completion rates**

02 **Initial contact rates**

03 **Monthly member contact**

04 **Quarterly face-to-face contact**

05 **Follow-up after hospitalization**

06 **PCP assignment**

07 **Care coordinator caseload standards**

These are contractual performance measures for PASSE organizations.

Key Takeaways

01 PCSPs and Treatment Plans are different documents.

02 Members direct person-centered planning.

03 PASSEs own PCSP development and care coordination.

04 Providers own treatment planning and clinical care.

05 Utilization Management determines authorizations.

06 Communication is essential.

07 Quality is measured through member outcomes.