MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services	**Addictive and Mental Disorders Division** Medicaid Services Provider Manual for Severe and Disabling Mental Illness
	Date effective: July 1, 2020 **Date revised:**
Policy Number: *SDMI HCBS 410*	**Subject:** Person-Centered Recovery Plan

Definition

The Person-Centered Recovery Plan (PCRP) is a written plan developed by the member and the case management team. It is intended to identify the strengths, capacities, preferences, needs, and desired measurable outcomes of the member. The PCRP outlines the services available to meet the member's identified needs as well as the cost of the identified services. This involves a planning process directed by the member, with assistance as needed or desired from other persons freely chosen by the member, who are able to serve as important contributors to the process.

Determination of Need

A member's PCRP is developed utilizing the current Level of Impairment (LOI), Level of Care (LOC), and Strength Assessment. The case management team (CMT) must document the member's need for each service authorized as indicated in the 'Determination of Need' section for the specific service(s) being authorized.

Requirements

(1) The CMT and the member must develop the member's PCRP within the first 30 days of a member's enrollment.

(2) The case management team must maximize the extent to which the member participates by:

(a) explaining the PCRP process;

(b) assisting the member to explore and identify his/her preferences, desired outcomes, goals, and the services and supports that will assist him/her in achieving desired outcomes;

(c) identifying and reviewing with the member issues to be discussed during the planning process; and

(d) giving each member an opportunity to determine the location and time of planning meetings, participants attending the meetings, and frequency and length of the meetings.

(3) The CMT must advise the member and/or guardians or the legal representative of the range of services and supports for which the member is eligible throughout the person-centered support planning process.

(4) Members, guardians and/or legal representative may choose among qualified providers and services.

(5) The CMT must:

(a) inform the member and/or guardian and legal representative they have the authority to select and invite individuals of their choice to actively participate in the person-centered support planning process;

(b) make reasonable attempts to schedule the meeting at a time and location convenient for all participants when scheduling to meet with the member and or member's legal guardian or representative;

(c) meet with the member in person at the time of the initial/interim and re-determination to ensure that the member is in the home.

(6) The PCRP must include the following components:

(a) demographic information;

(b) advanced Directives;

(c) medical Information such as:

(i) nutritional status;

(ii) medical diagnosis and diagnosis codes, for all services provided under SDMI HCBS waiver;

(iii) medication list;

(iv) allergies; and

(v) medication dispensing/pharmacy.

(d) psychosocial indicators;

(e) crisis intervention plan medical (who will contact my doctor?)

(f) a psychological crisis intervention plan which includes the following descriptions:

(i) what a crisis looks like for the member;

(ii) what wellness looks like for the member;

(iii) signs of relapse and triggers for the member;

(iv) interventions that have worked in the past;

(v) What the CMT needs to know about the member to be effective during crisis;

(vi) what the member feels is not helpful at the time of crisis; and

(vii) actions to be taken to address the member's needs.

(g) mental status/orientation;

(h) functional overview;

(i) assistive device information;

(j) the projected annual cost of SDMI HCBS waiver program services provided;

(k) other services and informal support systems;

(l) plan assessment which includes:

(i) psychological assessment;

(ii) physical assessment; and

(iii) goals using the SMART goal method.

(m) a discharge plan which describes elements and steps necessary for members to achieve independence;

(n) emergency backup plan, evacuation plan, and contact information;

(o) location of medication and important documents;

(p) safety information;

(q) the names of any relatives or legal guardians a member has chosen as a care provider; and

(r) the signature of the member or the member's legal representative which signifies the member's participation and agreement in the PCRP.

(7) The PCRP cost sheet is generated when the PCRP is developed. A new cost sheet must be completed at each annual update of the PCRP and when amendments are made to the PCRP.

(8) The CMT must explain the cost sheet to the member and/or the member’s representative.

(9) CMT may complete final cost plan upon return to office and document mailing of form to the individual and/or their representative.

(10) The CMT must review the cost sheet with the member at quarterly visits or as necessary.