Person-Centered Planning

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Chapter 1: Overview of Person-Centered Planning

Objectives:

- Understand agency accreditation purpose and options.
- Understand Person-Centered Plan*ning* and a Person-Centered Plan.
- Give examples of Person-Centered Planning values and actions.
- Understand the ND DD Section guiding principles.
- Understand the various stages of life and major tasks for each stage.
- Give examples of different kinds of support that lead to an inclusive, quality life.

Accreditation

In North Dakota, agencies are licensed by the ND Department of Health and Human Services, DD Section to offer services to people with developmental disabilities. Getting a license requires agencies to go through a formal accreditation process. To achieve accreditation, providers can choose between various accrediting agencies, including:

- The Council on Quality and Leadership in Supports for People with Disabilities (CQL) - An organization which provides accreditation and training for agencies providing services for people with intellectual, psychiatric, and developmental disabilities.
- The Commission on Accreditation of Rehabilitation Facilities (CARF) – An independent, nonprofit accreditor of health and human services.
- The Joint Commission – The Joint Commission accreditation can be earned by many types of health care organizations across the continuum of care, including behavioral health treatment facilities, and providers of home care services.
- National Association of Development Disabilities (NADD) - NADD offers accreditation for programs serving people with co-occurring IDD and mental health conditions.
- Council on Accreditation (COA) – Accreditation for social and human services, including behavioral health, aging, and services for people with developmental disabilities.

Person-Centered Plan*ning*:

To earn accreditation, agencies must use Person-Centered Planning which is a process designed to help people improve their lives and plan for their future. In this approach, the person works with their team to set goals and decide what steps and support will work best to help achieve their goals. The team includes people who know the person well and have been chosen by the person. The person uses their team to design a plan and help them solve challenges, meet personal goals, and live a meaningful life. This "person-centered" team meets to identify opportunities for the person to develop personal relationships, gain new experiences and skills, participate in their community, increase control over their own lives, and develop the skills and abilities needed to achieve their goals.

Person-Centered Planning depends on the commitment of a team to make sure that the strategies discussed in planning meetings are consistently implemented. The person supported should be empowered to guide the planning process to the best of their abilities/desires. Examples of how this can be supported will be reviewed in a later chapter.

The Person-Centered Plan

The Person-Centered Plan (PCP) is a written document that the team uses to write down goals, services, support, strategies, and decisions chosen by the person. This will work differently for each person. With input from the person, the team works to identify goals and dreams, as well as supports needed. Each Person-Centered Plan is designed to help that person reach their goals and live a meaningful life.

Life has meaning when you live in a place that you choose, have relationships with people you enjoy, and choose how to spend your time. Life involves work and play, challenges and comfort, familiar routines, and some adventure. People who live a meaningful life have choice and control over everyday events. They have continuity in their relationships, and they feel safe. Life has meaning when you are actively engaged and not just sitting around doing nothing. Life has meaning when you have a valued role in your group of friends and community (social roles). Life takes on meaning when you participate in the normal rhythms and activities for someone of your age and culture.

A Person-Centered Plan is a guide for the team to follow. Sometimes people are afraid to write goals that are really important but seem very difficult to accomplish. Many challenges can occur along the way. A Person-Centered Plan does not guarantee that goals will be met. The PCP is a 'living document' that must be reviewed regularly and changed to meet the needs of the person. Written plans help keep teams focused on the desired results.

Person-Centered Planning Values
Person-Centered Planning is most helpful when the team has a shared set of values. These values help the team to be respectful of each person and act in ways that are likely to help people supported to achieve a meaningful life.

The table below shows a list of core values and examples of actions taken by teams that match each value.

Core Values	Action
Learning is lifelong. People with disabilities can learn new skills and information throughout their lives.	**John is 56 and his parents are in their late 80's. He is helped to visit a funeral home and learn more about death and dying.**
Life has many seasons. Activities should be culturally and age appropriate.	**Susan is 19. She wants to sleep late and hang out with her friends in the evenings. Susan is supported to find a job in retail where she doesn't need to be to work before 10:00 am.**
Everyone learns in different ways. Most people do best when learning conditions and teaching methods are adapted to their strengths.	**Sara doesn't follow directions well when she is tired. She loves pictures and enjoys using computers. Staff helped her set up a picture reminder system on her computer.**
Everyone needs support and assistance sometimes. People with disabilities do not need to learn everything required for independent living before they can live where they want. They have the right to live in the community and receive the support they need to make it possible.	**Mike wants to live in an apartment but does not like to do house cleaning and other chores. He cannot afford a housekeeper. Mike gets an automated vacuum to help him do his cleaning. Mike's staff support him to do less preferred tasks by working alongside him, sharing their attention, and making it fun.**
Everyone is unique. Programs should fit the person and not the other way around.	**Ashley is referred for services. She uses sign language to communicate. No one who uses sign language has received services in the agency before. Staff members take an online course in sign language. They help Ashley teach new friends some signs too.**
Everyone should have choice and control in their lives. Person-Centered Planning is not about making people into "good workers" but about supporting people to set goals and realize dreams.	**Marge has been fired from several jobs for yelling and throwing things at co-workers. She is helped to make a picture list of what she needs to succeed on the job and to share that list with the team at her meeting. Marge is assisted to find a job that matches her interests and skills.**

Everyone learns from others. Some people may need more accommodation and support than others. Sometimes it is important to be shown how to do an activity and have lots of practice with support.	**Paula has a visual cookbook and utensils that are easy for her to use. However, these adaptations are not enough. Paula needs Jim to teach her how to tell when the hamburger is completely cooked, what to do when she cuts her finger, and how to get enough to eat without taking food from someone else's plate.**
Everyone has something to contribute. Everyone's contribution is valuable. We want to give people the opportunity to grow and succeed by encouraging them to do as much as they can for themselves.	**Mark is close to his family, and they know him well. If they continue to cook for him every night, he will remain dependent on them. They have supported Mark throughout his life, and they know what works and what doesn't. They may need support from the team to find a way to help Mark take more responsibility in this area.**

The policies of the Developmental Disabilities (DD) Section of the ND Health and Human Services state that every person should have the opportunity to define their happiness and the life they desire. A person's life goals can be achieved when family, friends, community, and service providers actively listen to what matters to a person, and respect values, strengths, culture, hopes, and dreams. Person-Centered Practices occur through the development and implementation of services and supports that are determined by a person's preferences, strengths, and choices. For Overall service plans, the DD Section follows these guiding principles:

- Emphasize Person First, with Customized Supports and Services
- Focus on the Person's Strengths
- Balance Choice and Risk
- Meet the Person Where They Are
- Regularly Review Goals
- Build Equity of Voice
- Equip the Person to Make Informed Decisions
- Be Kind

(2024, ND Developmental Disabilities Section*)*

When supporting people to plan for their future, it can be helpful to think about the different stages of life and a person's current stage of development as you help that person plan. *Charting the LifeCourse* is a framework that was developed to help people think about all stages of life, what is important to them at each stage, and to identify how to find or develop supports to live the lives they want. The chart below shows the different stages of life from birth through end of life. Person-Centered Planning at each life stage helps support a positive life and minimize negative life events. Having a vision for a good quality of life, along with opportunities, experiences and support, will move the life course of each person in a positive direction.

Life Stages
Prenatal/Infancy: From conception through the earliest year of life or babyhood.
Early Childhood: The time in a child's life before they begin school full time.
School Age: The years from kindergarten through middle school.
Transition: Moving from young adulthood and from school to adult life.
Adulthood: Period of time after we transition from school years to live life as an adult.
Aging: Slowing down and experiencing age-related changes; preparing for end of life.

(LifeCourse Nexus, 2024)

Self-determination means making choices, setting goals, assuming responsibility, and deciding how one's own life is lived. Self-determination should be part of the course of life from the very beginning. Person-Centered Planning helps people, and their teams create a meaningful life. Supports, resources and strategies can promote development and personal well-being. Types of support include agency-based services, technology, and community-based support. A combination of different kinds of support helps lead to an inclusive, good quality life across various life domains as shown in the table below:

Life Domains
Daily Life & Employment: What a person does as part of everyday life – school, employment, volunteering, communication, routines, life skills.
Community Life: Where and how someone lives – housing and living options, community access, transportation, home adaptations and modifications.
Safety & Security: Staying safe and secure – emergencies, well-being, guardianship options, legal rights, and issues.
Services & Supports: Services and supports for individuals and families – includes funded systems and natural supports; personal/family financial.
Healthy Living: Managing and accessing health care and staying well – medical, mental health, behavior, developmental, wellness, and nutrition.
Social & Spirituality: Building friendships and relationships, leisure activities, personal networks, faith community.
Citizenship & Advocacy: Support for families/individuals – peer support, self-advocacy.

These life domains are the different parts and experiences of life that we all consider as we age and grow. "Everyone (whether they have a disability or not) has to figure out: what they are going to do during the day– go to school, volunteer, get a job; where they are going to live; how they are going to stay healthy and safe; and so on." (Missouri Family to Family, 2015).

Chapter 1 Feedback Exercise

1. T/F The Citizenship & Advocacy life category involves peer support and self-advocacy.

2. T/F The Person-Centered Plan is a living document that must be reviewed and updated regularly.

3. T/F Person-Centered Planning is only important during the early childhood stage of life.

4. T/F People with disabilities must learn everything that is required to be independent *before* they can live where they want.

5. T/F Setting goals is a key part of self-determination.

6. T/F The core value “Everyone should have choice and control in their lives” focuses on making people into “good workers.”

7. T/F The core value "Learning is lifelong" suggests that people with disabilities can continue to learn new skills and information throughout their lives.

8. T/F Only family members are included in the person-center planning team.

9. What does a meaningful life involve according to the Person-Centered Planning approach?
   a. Living in a place chosen by the person, having relationships with people they enjoy, and choosing how to spend their time
   b. Following a strict daily routine set by the care provider
   c. Limiting social interactions to reduce stress

10. What is an example of the core value "Everyone needs support and assistance sometimes"?
    a. Susan works in a store where she doesn’t need to be to work before 10:00 am.
    b. Mike gets an automated vacuum to help him do his cleaning. Mike’s staff support him to do less preferred tasks by working alongside him, sharing their attention and making it fun.
    c. Staff members take an online course in sign language.

11. What are the guiding principles followed by the DD Section of the ND Health and Human Services?

12. How does the core value "Everyone is unique" effect program design?

13. How should activities be planned according to the core value "Life has many seasons"?

14. Why is self-determination important from the beginning of a person's life?

15. What does a meaningful life involve according to the Person-Centered Planning approach?

Chapter 2: The Person-Centered Planning Parts and Process

Objectives:

- Understand terminology related to the PCP parts and process.
- Identify common sections of a PCP and the purpose of each.
- Understand the importance of following the plan as it is written.
- Know when the team may need to meet to review the plan.
- Identify what is required to change the PCP.

Terminology

To understand the PCP parts and process, it helps to know terms that will be used. Common terms used across agencies during the planning and implementation of Person-Centered Plans include:

Person-Centered Plans: Over the years, agencies have used many different names for plans, including:

- Individual habilitation Plan (IHP)
- Individual Program Plan (IPP)
- Person-centered Service Plan (PCSP)
- Individual Education Plan (IEP) -used in school settings
- Essential Lifestyle Plan (ELP)
- Personal Futures Plan (PFP)

Now the plan is called the Person-Centered Plan (PCP), and the process of developing the plan is called Person-Centered Planning.

Qualified Developmental Disabilities Professional (QDDP) and Qualified Intellectual Disabilities Professional (QIDP): This job title describes the person within an agency who supports people receiving services to plan and coordinate their Person-Centered Planning process. Some agencies use other titles such as Case Manager, Program Manager, Program Coordinator, Program Specialist, or Service Coordinator.

Therap: Therap is a secure, web-based program that was designed to provide an electronic record for the planning, documentation, reporting, communication, and billing needs of organizations supporting people with intellectual and developmental disabilities in home and community-based services (HCBS) and other settings. Some agencies use Therap to share the Person-Centered Plan with other members of the team. Therap can be used to store information about a person's individual data, overall service plan, individualized service plan, health information, risk management, general event reports, and health tracking.

Overall Service Plan (OSP): The Overall Service Plan (OSP) is the individual service planning process in North Dakota for people with intellectual disabilities and related conditions. The OSP requirements are monitored through the Department of Health and

Human Services, DD Section. The OSP is developed by a QDDP. It can be stored electronically or in a person's physical files at the provider agency, and it is also sent to the person and the team members.

Assessments: Teams use assessments to gather information and make informed decisions during the planning process and development of the plan. Some assessments are required for ND DD providers, such as self-assessment and risk assessment (RMAP). Agencies may also conduct other assessments based on agency practices or when specific information important to the plan development is needed. The Community Staff Training Program (CSTP) *Assessment and Setting Goals* module can be reviewed for more information on this topic.

- **Self-Assessment:** This is required and should guide the planning process. The self-assessment will reveal the person's preferences, dreams, non-negotiables, and personal goals. Some agencies use the CQL *Personal Outcome Measures* as a guide for discussion on individual outcomes and goals. The self-assessment will reflect individual outcomes that are unique and specific to the person (2024, ND Developmental Disabilities Section*)* .

- **Risk Assessment:** The risk assessment is an important component of the overall planning process. It assesses the person's ability to stay safe and the need for safeguards. The presence of risks does not limit the person's opportunity to live in the community, have a job, or make their own decisions. The identification of risks and development of strategies to mitigate the risks are important to support people to live as they choose while adding support to assure their health and welfare.

- **Supports Intensity Scale (SIS)**: The SIS is a tool to measure the level of support required by people with I/DD to lead independent and quality lives. The SIS is administered by a qualified interviewer with feedback from one or more people who know the person well.

Plan Sections:
You should be familiar with the Person-Centered Plans for the people you support. Plans are individualized for each person, but these are some common sections of a written Person-Centered Plan, and the purpose for each:

Plan Section	Purpose
Cover sheet	A cover keeps the information inside private.
Personal information	Most teams include contact information, the date the plan was made, and facts about the person's age and gender.
Team members	This includes the names of the people who helped make the Person-Centered Plan. The team may change over time.
Background information (Social History)	Many Person-Centered Plans record important information about the person, their history, and their life situation such as jobs or the success of past Person-Centered Plans. This information may be a separate document, or included in the OSP. This summary includes individual experiences and what makes the person unique; skills, interests, personality, and values; what is important to the person, who is important to the person, non-negotiables, how the person communicates, strengths, likes, and dislikes. This information represents what is important to a person to feel happy, content, fulfilled, and satisfied.
Dreams, nightmares, and wishes	This information gives the team a vision for the kind of life that would have meaning for this person, as well as what the person does not want to be part of their life.
Strengths & needs	This section talks about personal preferences and what the person has accomplished. It also includes information about what kinds of support are helpful.
Goals/Personal Outcomes	Goals are broad statements about what the person wants to accomplish and why. A goal needs criteria so that the team knows when it has been met. More information about goals/personal outcomes can be found in the CSTP modules *Assessment and Setting Goals* and *Achieving Personal Outcomes*.
Learning Objectives	Objectives are outcomes or steps that, when met, lead to the achievement of a goal. Objectives need to be measurable and include a condition, behavior, and criteria. The CSTP module *Writing Behavioral Objectives & Measuring Behavior* can be reviewed for more information about this topic.

Support or Action Steps	Supports are unique to each person, and not a list of services provided by the agency. Teams often write out which support that staff need to provide throughout the day to keep the person actively engaged. This can include what to say and how to respond in specific situations.
Decisions or minutes	Sometimes teams record decisions or minutes so that team members who were not in attendance can learn what was discussed or decided.

As you gain experience in your agency, you will learn more about the Person-Centered Plan for each person you support.

Following the Person-Centered Plan

All team members need to follow the plan as written; this requires reading and understanding all parts of the plan. The Person-Centered Plan may include tips for communicating with the person, steps for teaching a specific task or activity, or ways to help someone stay calm when something happens that is upsetting. You may start supporting someone whose Person-Centered Plan has been in place for a long time or shortly after a Person-Centered Plan was developed. You must follow the Person-Centered Plan even if you do not agree with it. If the Person-Centered Plan is not clear, ask a supervisor or the QDDP for clarification.

The learning objectives will be part of a teaching plan and will require that data be collected so that progress can be monitored. Data is collected to assess the person's progress or lack of progress toward their goals. If a person is not making progress, this helps to encourage the team to identify possible barriers to success and methods that can be used to support the person around those barriers. If data indicates that a person does especially well with a specific staff, in a specific setting, with a specific type of positive reinforcement, etc., this also provides valuable information to the team regarding methods for supporting the person. What is this staff doing differently, what is it about this setting that supports the person to succeed (lighting, noise levels, the number of people present, etc.)? The team also supports the person to determine if the goal is truly meaningful and not a goal that the person accidentally agreed to or is no longer interested in achieving.

Changing the Person-Centered Plan

The plan is reviewed by the team at least annually. However, if there is a change in a significant part of a person's life, the team may need to meet to review the plan and make change. These may include:

1. Significant change in health status
2. Change in employment
3. Disruption of a significant relationship
4. New behavior challenges are noted
5. One or more goals have been met.
6. Events that might put the individual in harm's way have happened.
7. The person is acting in ways that will make it hard to achieve a goal.

8. The person experienced a life change, and the plan no longer makes sense.
9. The person doesn't have the resources needed to make the plan work.

A team meeting is required to make changes to a Person-Centered Plan. The current Person-Centered Plan should be followed until the team can meet unless doing so would place the person or others at risk of injury. Any member of the team can ask for a meeting to consider changing the Person-Centered Plan. At most agencies, the QDDP helps plan the meeting and coordinate support. It may take time to schedule a meeting, but the team needs to respond as quickly as possible.

Teams may include steps in the Person-Centered Plan that give the team some flexibility in carrying out the plan. See how one team did that for a person they support in the following example:

> *Dora met with her team to consider the support she might need to move out of her parents' home and live on her own. Because the team was not sure how this plan would work for Dora, they wrote a goal for Dora to try up to three different types of living arrangements: alone; with a roommate of her choice; or with a college student who was paid to share the apartment and provide support. Dora started the plan by living on her own. When she became lonesome and started bothering the neighbors for attention, Dora and her team realized it was time to switch to a different option. The team was able to respond quickly with the second phase of the goal*.

The support staff and other team members needed to talk often and work together to help Dora find a roommate and succeed in her goal to live apart from her parents. In Chapter 3 you will learn more about the roles and responsibilities of team members.

Chapter 2 Feedback Exercise

1. T/F Learning objectives in a Person-Centered Plan do not need to be measurable.

2. T/F The Person-Centered Plan must be followed as written, even if a team member disagrees with it.

3. T/F The QDDP typically helps plan the meeting and coordinate support when changes to the Person-Centered Plan are needed

4. T/F The Risk Assessment evaluate a person's employment history.

5. T/F The team reviews the Person-Centered Plan at least once per year.

6. T/F The background information (social history) section of a Person-Centered Plan includes information about the person's history and life situation.

7. T/F If a person is not making progress toward a goal, that goal should be removed from the plan.

8. What is the purpose of the Dreams, Nightmares, and Wishes section in a Person-Centered Plan?
   a. To record the person's medical history
   b. To give the team a vision for the kind of life that would have meaning for the person
   c. To list the person's daily routines
   d. To document the person's financial status

9. Which of the following is a reason to review a Person-Centered Plan more often than annually?
   a. One or more goals have been met
   b. Events that might put the individual in harm's way have happened
   c. The person experienced a life change, and the plan no longer makes sense
   d. all of the above

10. What is the purpose of a Self-Assessment in the planning process?

11. What should team members do if the Person-Centered Plan is not clear?

12. Why is data collected as part of the teaching plan in a Person-Centered Plan?

13. Why is it important to follow the Person-Centered Plan as written?

Chapter 3: Roles and Responsibilities of Team Members

Objectives:

- Understand what using a team approach means.
- Identify typical team members and their roles.
- Understand how team members are selected.
- Explain what role exchange means within a team.
- Understand the joint responsibilities of all team members.
- Know how to protect confidentiality of people supported.

The Team Approach

Each agency has internal policies and procedures to guide the Person-Centered Planning process. These policies and procedures may describe the ground rules for meetings, working through conflicts, and resolving disagreements. Policies specify who will carry out different roles and how the plan will be recorded and stored.

The Person-Centered Planning process uses a team approach. This means several people work together to assist the person supported to set and work on individualized goals. A team approach can be beneficial for many reasons, including:

- Some goals are better supported by more than one person.
- Teams can solve challenges about what might work better by thinking as a group and sharing experiences and stories.
- Teams bring together different ideas, views, skills, and knowledge.
- Team members share solutions and learn from each other.
- Team members help keep each other motivated when it might be easier to give up. This builds trust and helps ensure the person supported will achieve a life that is meaningful to him/her.

Team members work together to carry out the objectives and procedures in the Person-Centered Plan. In agreeing to this process, the team commits to giving the person supported the planned support he/she needs to meet the goals, and the active support needed to have a meaningful life. If any of the team members stop following the Person-Centered Plan, the process breaks down. If we follow the plan some of the time but do not provide consistency, progress may be slow, and the person may not be satisfied with services. Concerns about the plan should be referred to the QDDP.

Team Members

Each person's team is unique, and members are chosen by the person receiving services. Each team member has a specific role and responsibility. Examples of typical team members and their roles are given in the table below.

Person-Centered Planning Team Members	
Person being supported	This is the most important member of the team. This person chooses who else will be part of the team. The level of support needed to be actively involved in the planning process varies from person to person. Some people know what they want in their life and can state their goals clearly. They invite people to the meeting and will tell the team what kind of support they need. Others may need some support to structure the meeting and keep track of the decisions and outcomes. Some people need support to understand the Person-Centered Planning process. They may need someone to help them understand what is said or explain what might happen if proposed ideas are put into place. Sometimes people need help to prepare a list or pictures that show the team their preferences, progress, goals, and ideas. Chapter 4 will discuss strategies to support the person during the Person-Centered Planning process.
Qualified Developmental Disabilities Professional (QDDP)	This team member assists people to plan and coordinate their meetings. The QDDP needs to be organized, have good communication skills, and have the ability to lead the team in solving challenges and resolving conflicts. The QDDP meets with the person before the meeting. The QDDP may lead the meeting and the team discussion if the person chooses not to, and summarizes the results of the meeting.
Direct Support Professional (DSP), Job Coach	Support staff are among the most important members of the team. They help the person at home, at work, and in the community. They are in the best position to see if the Person-Centered Plan is working, if the person is receiving active support, and to help with daily problem solving. The information DSPs document daily helps to determine if progress is being made. DSPs may be asked to help a person prepare for their meeting. They may also complete assessments prior to the meeting. DSPs play an important role in helping people with disabilities understand the discussion and decisions made during the meeting. If DSPs are unsure of what to expect, they should ask their supervisor or the person responsible for planning the meeting about what to expect and how to prepare. DSPs will be carrying out the Person-Centered Plan, so they need to understand and know the plan well.

Guardian	Each person becomes their own legal guardian at age 18 unless the court appoints a parent or someone else to serve as a guardian. Agencies cannot share confidential information with parents after their child with a disability reaches the age of 18 unless the person with a disability signs a release that allows the agency to share information with their parents, or unless the parent or someone else has been appointed by the court to serve as a legal guardian. The role of the guardian may be limited to certain areas of responsibility such as financial, medical, or legal decisions. Sometimes the guardian may be responsible for all decisions. If a guardian is appointed, it is the guardian's responsibility to make decisions based on the person's wants and needs and how the person chooses to live their life. Planning decisions should not be based on the guardian's or agency's preferences. Supported Decision-Making is a less restrictive option that may eliminate the need for guardianship. Supported decision-making promotes self-determination, control, and autonomy, and fosters independence. When supported decision-making is used, the person consults with trusted people, such as friends, family members, or professionals to weigh the pros and cons of a decision.
Family	Most people supported choose to have family members take part in their lives, and to have family share information about them. Sometimes family members are more involved during critical times in the person's life. For example, the person might need family support when moving, recovering from surgery or illness, or when a crisis occurs. The relationship between child and parent changes over time to an adult-adult relationship. As parents age, other family members may take over some support or decision-making roles in team meetings.
Consultants and Other Professionals (i.e., dietitian, physical therapist, physician)	Various professionals may help with the planning process depending on the needs and preferences of the person supported. Examples may include health care professional, behavior specialist or psychologist, speech therapist, employer, co-worker, occupational therapist, minister, or counselor.
Friends or Co-workers	Sometimes people invite friends, classmates or co-workers to help develop their Person-Centered Plan or attend a meeting to offer support. As people move away from their parents' home, sometimes friends and co-workers become more important in their lives. When friends or co-workers are invited to a planning meeting, they should be given an active role in the

	meeting. They may need encouragement to speak up as this experience may be unfamiliar to them.

As indicated in the table above, teams include people who know the person well, and people who can provide information that will help the team make important decisions with the person. Some people ask their families to participate, and some do not. Some people may have a legal guardian to help them make decisions. Read about Mary and some of the people included in her team.

> *Mary is 34 years old. She is legally capable of making her own decisions, but has asked Quinn, her QDDP, to help plan her meeting. Mary has worked at the local grocery store for eight years and she has a job coach who helped her learn the job and supports her employment. Mary asks her job coach to be on the team. Mary asks her friend Susan to be part of the team, Susan lives down the hall in Mary's apartment building and they have been friends for two years. She asks Alex to be on the team. He is a DSP who helps Mary budget her money and assists Mary with shopping on weekends. Mary asks a nurse from the agency to come to her meeting because Mary has diabetes and needs good information about her health. Mary also asks her sister Darla and her Aunt Ashley. Quinn helps Mary get the team together and select a location. Quinn suggests that Mary invite her boss, she explains that Mary has worked on the job for some time and might not need a job coach in the future; her boss could help her feel confident about trying the job on her own.*

Some of the people on Mary's team help support her at home and on the job. They are important because they can help Mary set new goals and meet them. Some members of the team provide special expertise in some areas. Some team members attend because they are family and friends. Mary is comfortable with her large team and the people she knows well. She is private about making life decisions but willing to have her boss attend because someone she trusts asked her to consider this.

Here is another example of choosing team members based on the person's strengths, needs, and goals. Bob's team is smaller than Mary's.

> *Bob is 29 years old. He is blind and deaf, has significant intellectual disabilities and is in good health. Bob's awareness of his world is limited to having a familiar routine and looking forward to his favorite meals and activities. People who know Bob well sign words into his hands to communicate. Bob feels the signs in his hands and recognizes a few signed words. For example, when the sign for "pop/soda" is pressed into his hands he smiles and smacks his lips. Bob is not aware that he has a team or what it means to have a goal. Bob has been willing to try new activities. For example, Bob tried riding in a tandem go-cart for the first time and used his sign for "more" several times when the ride was finished. Bob does not like to manipulate objects or do work that he does not understand so he has a volunteer role taking food items from various sites to the local food pantry. Bob likes loading and unloading these groceries.*
>
> *Bob's father attends his meeting. He is Bob's legal guardian and helps him make financial, medical, and legal decisions. Bob's team meets in Bob's living room after*

work. Char, who helps Bob at home, is there. She has supported Bob for six years. Melanie is there too. She met Bob about two weeks ago and supports him in his home. The speech therapist, Cindy, is there. Cindy designed the communication system to help Bob connect with his world. Frank is there too. Frank assists Bob with his volunteer route. Bob's team is small. They have a lot of responsibility to help Bob live a meaningful life.

Role Exchange

People may not always accept support from someone they do not know well. They may not trust a team member with the most expertise if that person hasn't spent time with them. When a specialist is unfamiliar or is not available to visit the person at home or on the job prior to a team meeting, teams use a process called role exchange. The person with expertise often trains a direct support professional to provide specific support. The direct support professional teaches the specialist about what works for each person. The two team members learn from each other in order to help the person with a disability. Learning from each other is called role exchange. Role exchange is a powerful tool that teams use to work together. The following example shows how a role exchange can work:

After the meeting, the speech therapist teaches everyone who communicates with the person receiving services to use specific communication techniques, such as sign language or a picture board. Parents, job coaches, residential support staff, behavior specialists, and nursing staff all begin to use these techniques whenever they visit the person. The speech therapist monitors the person's progress, answers questions, and revises the program as needed.

People receiving services are more likely to try the new techniques when they are used by others they know and trust. In addition, this approach helps the person learn and practice communication skills in natural settings, increasing the likelihood the person will use these skills.

Joint Responsibilities
Teams that have a positive outlook and support each other will create the best plan possible. Everyone has the responsibility to be on time, dress appropriately, respect others, listen, and share ideas and concerns. All team members have a responsibility to use language that considers the person's age, and is easy to read, and understand. This includes using simple words and phrases while avoiding jargon and technical terms and avoiding abbreviations that are not common to everyone.

Confidentiality is a responsibility shared by all team members. Anything discussed during the team meeting is confidential information. Policy and procedures regarding confidentiality are based on legal requirements and sharing information on a "need to know" basis. Information should not be overhead by someone not authorized to have that information. Remember that even when the person's name is not used, other people may identify the person being discussed. The rule of thumb is to simply not talk about events that happen within the agency when you are outside of the agency, or with other employees who do not have a need to know. This protects not only the person but also the agency from liability for sharing information without proper consent. In addition, information should always be shared in a professional manner.

To share information outside the agency, it is necessary to obtain signed authorization to release confidential information. If you have doubts about information being shared outside the agency, contact your supervisor or QDDP. Even what appears to be an innocent question by someone could be a breach of confidentiality. Answering a question such as "Did Janet attend the day program today?" can be a violation of the person's confidentiality when that information is shared with someone outside the agency or even within the agency if they do not have a need to know that information.

Protect Confidentiality

- Do Not provide information about a person you support to anyone outside the agency without the individual or guardian's written consent.
- Do Not discuss a person you support in a public place.
- Do Not discuss people you support with other staff unless the information needs to be known by all staff involved with the conversation.
- Do Not engage in social media regarding people you support.

Before sharing any information consider these questions.

- How much information does the person and/or their guardian want to share?
- Is there anything on printed information that indicates a person has a disability?
- Is there anything on documents that tells people the person has a plan associated with having a disability (example –a PCP)?
- Is any of the information deeply personal that the person or the family/guardian would like to remain private?

Chapter 3 Feedback Exercise

1. T/F The Person-Centered Planning process uses a team approach.

2. T/F Confidential information should only be shared on a "need to know" basis. True

3. T/F The person being supported does not have a choice in choosing their team members.

4. T/F Role exchange involves team members learning from each other to support the person with a disability.

5. T/F Discussing a person's attendance at a day program with your neighbor is a potential breach of confidentiality.

6. T/F Confidentiality is a responsibility shared only by team members that oversee health issues.

7. Which of the following is NOT a benefit of a team approach in Person-Centered Planning?
   a. Teams bring together different ideas and skills.
   b. Teams can solve challenges by thinking as a group and sharing experiences.
   c. Teams ensure that only one person is responsible for all decisions.
   d. Team members learn from each other.

8. Who is the most important member of the Person-Centered Planning team?
   a. Qualified Developmental Disabilities Professional (QDDP)
   b. Direct Support Professional (DSP)
   c. Person being supported
   d. Guardian

9. What is the purpose of role exchange in the Person-Centered Planning process?
   a. To replace the person with a disability in the planning process
   b. To train a direct support professional to provide specific support and teach the specialist about what works for each person
   c. To eliminate the need for team meetings
   d. To ensure only one person is responsible for all decisions

10. Which of the following **IS** a responsibility of all team members during meetings? Mark all that apply.
    ____ Be on time
    ____ Dress appropriately
    ____ Use abbreviations for job titles (i.e., DSP)
    ____ Respect others
    ____ Use language that is easy to understand

11. Match each team member with their role.
    a. Direct Support Professional (DSP)
    b. Person Supported
    c. Qualified Developmental Disabilities Professional (QDDP)
    d. Sister
    e. Guardian
    f. Speech Therapist

    ___ Provide specialized knowledge and support based on the person's needs and preferences.
    ____ Document daily progress and assist and daily problem solving.
    ____ Offer support.
    ____ Make decisions based on the person's wants and needs and how the person chooses to live their life.
    ____ Chooses who will be part of the team.
    ____ Assist the person supported to plan and coordinate their meeting.

12. Describe the role of a guardian in the Person-Centered Planning process.

13. What is Supported Decision-Making and how is it different from guardianship?

Chapter 4: Supporting People to be Active in Their PCP Process

Objectives:

- Understand the importance of and how to use active support.
- Identify the core elements of active support.
- Give examples of engaging people in various planning and meeting activities.
- Give examples of ways to celebrate success.

This chapter will give examples of how to support people to be active participants in creating and participating in their own Person-Centered Plan. The specific strategies to use depends on each person and how the person communicates, learns, and remembers information. Over time, changes or modifications to the strategies may be needed. General guidelines include:

- Get to know the person you are supporting well. Understand what is important to the person, how they communicate, and their strengths and challenges.
- Be sure the person has input into the development of their Person-Centered Plan.
- Be sure the person has a copy of their Person-Centered Plan.
- Use symbols and language the person can understand.
- Use active support.

Active Support

Active support is a person-centered approach to providing direct support. The goal of active support is to ensure that people, including those with the most significant disabilities, have ongoing support to be engaged throughout their day. Ensuring that people with disabilities are engaged can be a challenge in many support settings. DSPs have multiple job duties and need to complete many tasks, making it easy to take on a caregiving or parenting role. However, when you do things *for* people, it takes away opportunities for them to make choices, be engaged, learn new things, and interact with others.

The core elements in the definition of active support include: helping people to be actively, consistently, and meaningfully engaged in their own lives regardless of their support needs. This is what these terms mean:

Actively – Each day, throughout the day whenever there is an opportunity.
Consistently – With approaches that provide enough structure and routine that people experience comfort, continuity, and have a better ability to be engaged.
Meaningfully – in ways that

- increase competence and opportunity
- help people be and stay connected to others
- enhance self-esteem
- are focused on the needs, preferences, and goals of the person

Engaged – Doing things, participating, spending time with others, making decisions, making choices.

The purpose of active support is not to manage people or keep them busy, but to help them participate meaningfully in their own lives. Some self-advocates have used the phrase “Work

with me, not on me. Do *with* me, not for me" to emphasize the need to be included in all aspects of their own lives.

Active support is consistent with the concept of partial participation, which is based on the belief that everyone is capable of completing some part of any activity. Partial participation helps people be actively engaged in their own lives by participating as much as possible in any activity, even if the person is not able to do the entire task. There are many ways to use active support and partial participation. Some general examples are given below. More specific examples related to team planning are given within chapter sections.

- When checking out a new pottery shop downtown, the support staff makes sure to include Connie in conversation with the shop's employees. When the employee asks the support staff if Connie is interested in signing up for a pottery class, the support staff turns to Connie and says, "What do you think?," and waits for Connie to respond.

- Julie has limited sight. While at a local coffee shop, the support staff guides her to a clear path to the counter so Julie can order her own coffee drink. Staff read the options from the menu and Julie nods when she hears one she wants.

- Val loves to be involved in grocery shopping for the neighborhood picnic. Val doesn't read words, so staff assist her to make a picture shopping list, so she can remember which items she needs when she is at the grocery store. While at the store, Val pushes her own cart and finds the items on her list, while staff push their own cart and find the items on their list.

- Jeff waters the flowers outside of his home by holding the water hose while staff push his wheelchair along the path.

Active Support is helping people to be
actively, consistently, and meaningfully engaged
in their own lives
regardless of their support needs.

Choosing a place for the meeting
The Person-Centered meeting does not have to be in a traditional place such as the provider agency's meeting room. A board room can be uncomfortable or intimidating for some people. Team meetings should take place where the person supported will be most comfortable and with enough space for the size of the group. The person supported should be empowered to choose where they are comfortable meeting. Some ways to assist people to choose where their meeting will take place include:

- Take them to different locations so they can see the choices.
- Show them pictures of various locations they can choose from.
- Talk about what might be good and not so good in each location. Things to consider would be the physical location to the rest of the team (travel time), noise level, accessibility, seating, etc.

Inviting people to the meeting
One of the first steps staff can take to involve people in creating their Person-Centered Plan is to assist them to invite people to their meeting. Steps for the person to consider include the following:

- Meet with the QDDP before the meeting.
    - Look at pictures or names of people.
    - Select people to invite.
- Use simple words and clip art to make an invitation to the meeting. An invitation could be made with paper, email, or text.
    - Deliver the invitation in person, postal mail, or by email or text.
- Use a pre-recorded phone message to invite someone.

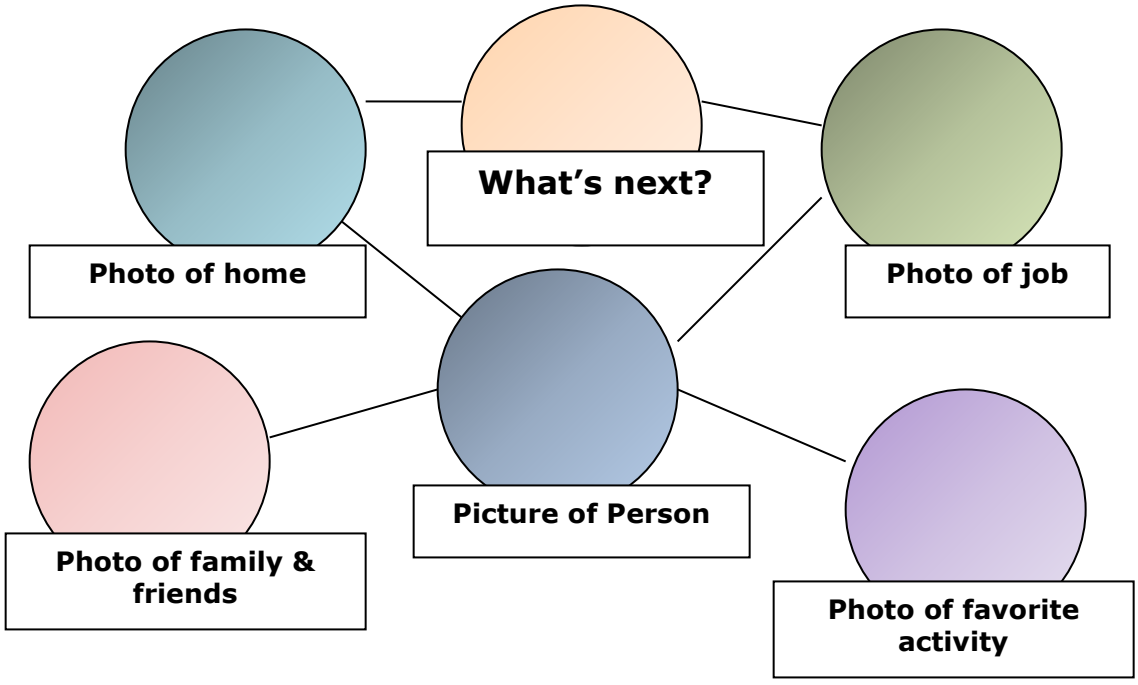
- Put a sticker, clip art or reminder for the meeting on a calendar.

Send a reminder to others that you invited as the date draws near.

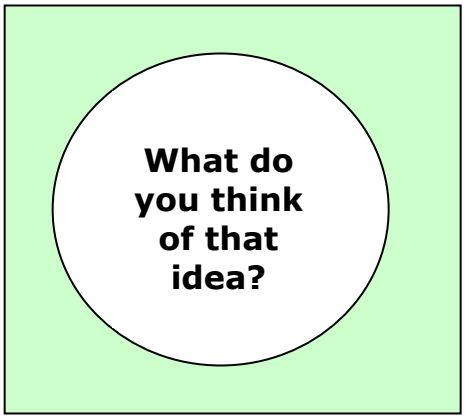
- Ask someone else to take care of these details for you.

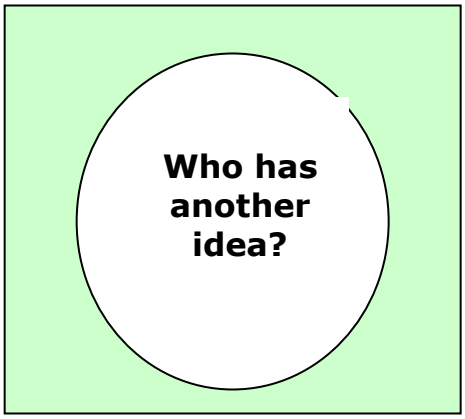
Sharing information in the meeting
Information shared in the meeting should include the person's goals, dreams, nightmares, and wishes. It can also involve talking about strengths and needs. During the meeting staff could assist the person to be involved in sharing information by using the following strategies:

- Give the person a signal that it is time to share information.
- Assist the person to bring information and ideas in a format he/she can share and understand. For example, the person could share ideas by clicking through the slides in a PowerPoint
- Invite other people who know them well to contribute their ideas and information.
- Explain what other people are sharing or saying about them.
- Talk through how to tell others if they agree or disagree with what is said.
- Put together a collage, scrapbook, or photo diary of key events.
- Use concept maps to display important points about a person, for example:



- The person could use switch devices to activate a message or make statements that direct the group to respond. Example:





Reviewing the current Person-Centered Plan
At some point before or during the meeting the team will discuss current goals and objectives to determine if they are met. To help people understand progress toward goals the team can use many different ideas:

- A pie chart can show how much of a goal is accomplished.
- Glasses that are full, partially filled, or empty.
- A game board with the goal written at one end and a path leading to the goal. A figure on the game board that can be moved back and forth.
- An hourglass that is flowing or has run out.
- A picture of a head and shoulders with key thoughts the person shared. The person's ideas or suggestions by other members of the team can be listed or displayed in bubbles around the picture.

These activities are just examples. Be creative and try different ways to help the person understand what is happening and participate at some level in reviewing their Person-Centered Plan.

Some people will not be able to understand these ideas, so develop an understanding or awareness of:

- How satisfied the person is with their daily routine. The routine should reflect activities that are helping the person achieve their goals with their interests, strengths, and preferences in mind.
- How well the routine works to help the person achieve their goals.

To help people understand concepts about satisfaction with a daily routine, the team can use these ideas to involve the person in communicating about their day:

- Bring objects representing the activities they like or dislike to the meeting. Show them when discussing those specific activities.
- Bring photos of the person in moments that show a positive or negative reaction to activities or events.

Pictures can also be used outside of the team meeting to help people understand a Person-Centered Plan, for example:

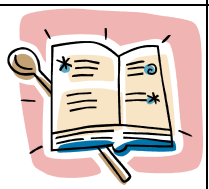
> *The DSPs supporting Mary know she likes having choices. The team decided to try having Mary pick who will help her with lunch by using pictures of the DSPs working at the time of the meal. Pictures are placed in front of her before the meal, Mary selects by touching or looking at the picture. This is followed up with the statement such as "Mary you would like Pam to help you with lunch today, thanks for letting us know." Mary may smile or comment by vocalizing.*

Capturing team discussion and decision-making
Assist people to understand and remember what has been discussed and decided. There are many different ways to assist a person with this process, including:

- Ask someone to record notes for the team during the meeting.
- Use a large font.
- Write only key phrases and use clip art icon or pictures. Don't worry if the objectives are perfectly worded for the purpose of this activity. The QDDP can work on the wording required for a measurable objective after the meeting.
- Ask the person to approve or add to sections.
- Give this to the person at the end of the meeting.

An example of this approach is shown below.

John's Person-Centered Plan

	Goals & Objectives (just enough information to get the team to understand the main idea)	**Help & Support**
At work 	Get a job at Taco Johns • Apply for work • Take a tour • Interview • Get hired	Jody will help John do one step each week until the goal is met.
At home 	Learn to cook 3 Italian meals by himself • Spaghetti • Hot dish • Lasagna	Pete will help John follow a simple recipe for the spaghetti and hot dish. They will use a microwave lasagna for that meal. They will cook 2 x a week.
In the community 	Invite a friend to join him for popcorn & a movie twice a month without help.	Pete and Joe will help John learn to: • Call a friend • Rent a movie • Buy a ticket • Make choices

This Person-Centered Plan does not have all the words or criteria that the team may need, but John can understand what is being planned. More pictures can be added if needed. DSPs can help to create this type of chart at the meeting, or after the meeting. It could be posted somewhere the person chooses within their home, such as on the fridge or in the person's bedroom.

Directing Team Activities

Some people may coordinate their own meeting. In most cases the agenda and discussion are led by the QDDP; however, some people may coordinate their entire meeting or manage some of the tasks themselves. Having a sense of choice and control is important for the development of self-determination.

People who do not coordinate their own meeting may not know what to say, when to speak up, or haven't been given the opportunity. The process of leading the team can be broken down into smaller steps and people can be encouraged or taught to take responsibility for some or all of these steps. Some teams have had success by:

- Encouraging people to learn and use one or two steps.
- Giving people lots of chances to lead or organize activities throughout the year.
- Helping people keep "problem solving" logs of how to handle different challenges.
- Putting all the steps into a PowerPoint and having the person lead the meeting by clicking on the slide with the questions pre-printed for the team. For some people it might be helpful to embed an audio recording of the question in the PowerPoint.

Visualizing Goals and Objectives

A person's goals should guide the rest of the plan. The self-assessment tool will help the person and their team to identify and set goals and steps to meet the goals. Module 55-*Assessment and Setting Goals*, and module 18-*Achieving Personal Outcomes* in the Community Staff Training Program curriculum provide more information about conducting assessments that can lead to setting and achieving goals. Self-assessment is an important tool which puts the person supported at the center of their own planning process.

Talking about, visiting, or looking at pictures of people or places can help people supported to think about what other people their age are doing with their lives, where they live, where they work, etc. Bringing photos or objects that represent future possibilities to share at the meeting is one way for people supported to share information with the team about their goals and preferred lifestyle.

This same process can be used to represent "nightmares" or worst-case scenarios the person wants to avoid. It is useful for planning teams to collect a gallery of work or living option photos. This can be a fun and informative activity when staff include the person supported in the search. Looking for images and talking about possibilities helps direct support professionals to learn what is important to the person. It also helps us find out what the person doesn't know and experiences that might help the person achieve a more meaningful life.

Measuring Goals or Objectives

People supported may need assistance to use their Person-Centered Plans as a guide for decision making after the team meeting. Support can include:

- Assist the person to put a reminder on their calendar to review their Person-Centered Plan at periodic intervals.
- Assist the person to share his or her Person-Centered Plan with others as they wish.
- Assist the person to cross off or initial steps of their plan that have been completed.

There are many different approaches that teams use to involve the person in determining if a goal has been met. Remember that often people supported will tell us what they think we want to hear. So, it is important to encourage people to say what they really think about how things are going. Here are some ideas teams have used.

1. Video the person doing an activity. After watching the video together, answer questions about what has been accomplished.
2. Create a folder or scrapbook of accomplishments. Adding to this from time to time helps the person notice what they are doing well. It's good for self-esteem and can serve as motivation to learn new things.
3. Make a list of steps or goals you think the person has achieved. Invite someone they trust to review the list. See if they agree. If not, decide together what needs to happen. This approach puts the person in the driver's seat.
4. Use objects or counters whenever a task or goal is attempted. Help the person decide on an all-or-nothing basis. Example: All the boxes are filled means the goal is met.
5. Use bar charts or line graphs to show progress so that when the line is at the top or enters a shaded area, the goal is met.

Opportunities for Practice

People need opportunities to practice new things, including any of the strategies mentioned in this chapter. Practice involves trying something over and over until a person is comfortable with it.

Although a person supported may have gone to many meetings, that does not mean they have observed what other people at the meeting were doing. They may be aware that someone was talking and even commented themselves. That does not mean they will be ready to model that behavior. They may need to see it, hear it, and practice it many times.

Celebrate Success

When people supported have accomplishments, they should be celebrated.

- Bring a cake
- Make a toast
- Give a certificate
- Make an announcement
- Give a round of applause
- Take pictures
- Put a page in the scrap book
- Make a video the person can replay

The specific examples presented in this chapter can help you find creative ways to get involved in helping people take charge of their lives and make plans for the future.

Chapter 4 Feedback Exercise

1. T/F Using complex language is a good way to support people to participate in their Person-Centered Planning meeting.

2. T/F Partial participation is based on the belief that everyone can do some part of any activity.

3. T/F Giving people choice and control is important for the development of self-determination.

4. T/F Using symbols and language that the person can understand is important in the Person-Centered Planning process.

5. T/F Self-assessment is an important tool that puts the person supported at the center of their own planning process.

6. T/F The goal of active support is to manage people and keep them busy.

7. What does the term "engaged" mean when using active support?
   a. Doing things, participating, spending time with others, making decisions, making choices
   b. Sitting quietly and observing
   c. Following instructions without question
   d. Avoiding social interactions

8. What can be used to help people think about their goals and preferred lifestyle?
   a. Give them a handwritten copy of their current plan
   b. Talking about, looking at pictures, or visiting people or places
   c. Only discussing worst-case scenarios
   d. Avoiding any visual aids

9. Which of the following is an example of how to help a person understand progress toward their goals?
   a. Use line graphs with progress points
   b. Do not discuss progress at all
   c. Using only written reports
   d. keep a folder with pictures of their accomplishments

10. What are three ways that people with disabilities can be supported to invite others to their meeting?

11. What is one strategy to help a person share information during their planning meeting?

12. What is the goal of active support?

13. Describe the concept of partial participation.

14. What is the purpose of celebrating success in the Person-Centered Planning process?

15. Explain the importance of providing opportunities for practice in the Person-Centered Planning process.

Chapter 5: Working Together

Objectives:

- Identify activities that happen before, during, and after the meeting.
- Identify how you can be involved in team planning before, during, and after the meeting.
- Describe how the team uses shared values to guide the decision-making process.
- Explain consensus decision-making process.
- Explain what team members should do if challenges are identified.

It is important for staff and the person supported to know what to expect during the Person-Centered Planning process. Different teams organize the process and meetings in different ways. Although the Person-Centered Planning is an ongoing process, it can be helpful to think about the process in three phases: before the meeting, during the meeting, and after the meeting. Here are some common strategies that teams often uses to create or change a Person-Centered Plan.

Before the meeting

There are several important steps to prepare for a meeting:

- **Get to know the person.** Learn as much as you can about the person's interests, dreams, strengths, goals, and satisfaction with their current life.

    - Ask about his or her life.
    - Talk to others who know the person.
    - Read past plans together.
    - Ask about preferences.
    - Visit the person at home or work.
    - Spend time with the person. Look at scrap books.
    - Go out for coffee together.

- **Participate in assessments** assigned by your supervisor or the QDDP. These may include self-assessment, risk assessment, or other specific assessments related to employment, community involvement, care, or self-management. Review the results of all assessments that are completed in preparation for the meeting so that you are ready to participate in discussion at the meeting.

- **Review the current Person-Centered Plan.** Note the progress made or challenges encountered. What was supposed to happen? Did it? How effective is the current plan for this person? List solutions to possible challenges or barriers to any goals that are important to the person you are supporting.

- **Prepare to write effective, measurable goals and objectives.** Find out how to take good ideas and create measurable goals so you can participate in this part of the Person-Centered Planning process.

    - Complete the *Writing Objectives and Measuring Behavior* module (required for QDDPs).
    - Ask your supervisor or the QDDP to show you some well written goals/objectives before the meeting.
    - Look at the person's goals from last year and think about what would have to happen to meet each goal.

- **Practice a positive approach.** Practice sharing your observations and ideas in positive terms. A positive approach helps make sure that everyone has a chance to share ideas and get support. This includes not only the people we support but also your co-workers, the supervisory staff, and consultants. Remember to show respect even when speaking of someone who provides services but is not at the meeting (example - a physician).

- **Assist the person supported to plan for the meeting.** Create your own ideas or use the ideas from chapter 4 on how to support the person to be actively engaged in their own Person-Centered Planning process. This might include inviting people to the meeting, reviewing their current plan and progress, and completing a self-assessment.

<u>During the Meeting</u>

Knowing what to expect at a meeting can help to put staff and the person supported at ease. The person may facilitate their own meeting, or the QDDP may lead the discussion if the person chooses not to. As discussed in chapter 4, use strategies to assist the person supported to be actively engaged during their meeting. These are general guidelines for all team members to follow, and things that generally happen during a team meeting.

- **Welcome and Introductions.** The meeting facilitator may invite everyone to share their name, tell what their connection is to the person, or explain what role they have on the team. Titles such as job coach, DSP, trainer, should not be used. Titles are more formal and are often not understood by people supported or their families. Examples of good ways for team members to introduce themselves include:

    My name is Alice. Melissa asked me to help her lead the meeting today."

    "Hi, my name is Ron, and I support Melissa in her job at the mall."

    "I'm Fred Parker. I help Melissa in her home."

"Hello, I'm Patty and I'm a nurse. Melissa has diabetes and I'm here to help Melissa and the team with any questions about Melissa's health care."

- **The general purpose of the meeting is reviewed.** The outcomes which are necessary and expected as a result of the meeting will be identified. For example,

  "We're here to help Melissa plan and set goals for the next year.

  "Melissa, you invited us over to help you plan and set goals this year."

  "Mr. and Mrs. Gardner, Melissa's legal guardians, asked for a meeting with Melissa's team. They don't believe the behavior support plan is working and want to review it with the rest of the team."

  Each of these statements describe a different type of meeting and helps the team understand the work that needs to be done. When the purpose of the meeting is very specific, the purpose of the meeting should indicate that, for example,

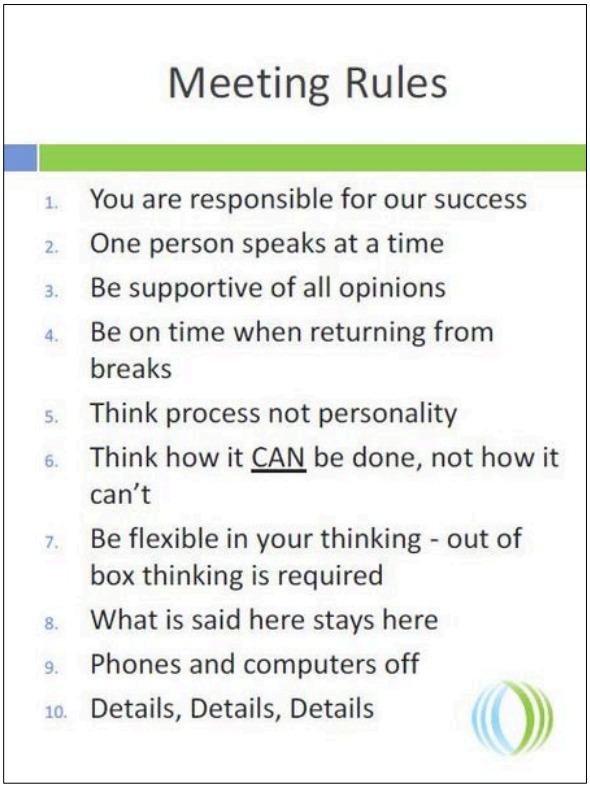
  "We need to decide how to respond to a health issue Maggie is experiencing."

  "We're meeting today to help Gary make decisions about a job option." Or "to consider the impact of a new job on Gary's lifestyle."

  "Kathy wants to discuss removing restrictions on her rights."

  "We are meeting today to discuss Robert's choices that place him at risk."

- **Rules on how the meeting will be conducted are reviewed.** Teams sometimes use *ground rules* at meetings. Discussions about rules can include how decisions will be made, when to ask questions or express ideas, time limits etc. Respect is demonstrated by taking turns, listening, brainstorming etc. Sometimes these rules are written down on a wall poster so everyone can see them throughout the meeting. They can be shared at the beginning of the meeting with a quick reminder like the examples listed in the picture.



- **Use language everyone can understand.** Team members should avoid technical terms and acronyms (letters that stand for long titles). For example, many agencies refer to "medication administration." But families or people with disabilities may not fully understand that term. The words "giving medicine" are easily understood by all. Everyday vocabulary works best.

  Some technical terms can't be avoided. For example, if you are supporting someone with diabetes, the words "low blood-sugar" will probably be used. Be sure you define these terms for people who might not understand. Terms that should either be avoided or carefully explained are the names of tests, special intervention techniques or places, and titles or activities that might be unfamiliar to team members who are not employees or health professionals. Use clear language to clarify the difference between facts and beliefs. If you are expressing an opinion or a personal feeling, let everyone know it is not a fact. Always make the difference between fact and opinion clear when sharing information.

- **Be a good role model:** All team members should act in a professional manner during the Person-Centered Planning meeting. General guidelines include:

Professional Appearance	Professional Behavior
• Use good hygiene • Leave T-shirts with slogans at home • Wear clothing that isn't revealing • Don't use chewing tobacco • Don't chew gum • Follow the agency dress code	• Show up 5 minutes early • Turn off your cell phone • Don't read or respond to text messages, put your phone away during the meeting. • Bring a pen/notepad • Listen, don't interrupt • Take turns • Remember to smile

- **Participate, speak up and respond.** It is important for all team members to participate in the meeting and not just be an observer. Think about contributions you can make, write them down and bring them to the meeting. Make and bring a list of five key ideas/things that you know are important to the person. The information shared by team members is used to assist the person build a meaningful life. In the information-gathering phase of the meeting, participants may:

  - Share ideas about strengths, needs, and preferences.
  - Report progress made on the current plan. Discuss if goals were met.
  - Report the results of any assessments that were done.
  - Share observations about recent events that may impact the person.
  - Include new ideas, interests, goals, or experiences that shape the future vision.

  Silence in the group may be interpreted as agreement. For example, if a goal is proposed and no one objects then the team leader may assume everyone agrees and move on to the next step. If you have a concern it is your obligation to speak up and voice your thoughts.

- **Decision Making.** There are many decisions that are made during a Person-Centered Planning meeting. The team evaluates all proposed goals and determines if they match the person's priorities. Services and support needed to achieve the goals are identified and selected. Strategies to achieve objectives are decided. Decisions are made for measuring, monitoring, and evaluating progress.

  The team uses shared values to guide the decision-making process. These values were learned through discussion with many people who have disabilities and their families. These values help to enhance lives and opportunities. Each value and examples of how it might be used are listed in the chart below.

Team Value	Person-Centered Example
1. Help the person achieve outcomes which are important to them.	• Get a certain job. • Meaningful activities. • Choose where to live. • Spend time with family & friends.
2. Help the person move from a position of dependence toward a position of independence.	• Dish up own food. • Take medication safely without help. • Cook own meals. • Wake up to an alarm clock.
3. Help the person move from powerlessness toward having more control over his or her environment.	• Control who enters by locking the door. • Give a signal when ready to be lifted. • Make a choice of what to wear. • Learn how to ask for help.
4. Help the person move from basic to more complex behaviors to adapt or cope with more and more complex situations.	• Call a friend and make plans. • Take turns in a conversation. • Make a full meal instead of heating up pre-made items. • Use the stove and the microwave.
5. Help the person move from negatively valued behaviors to more positively valued responses.	• Say "No," instead of sitting down on the floor. • Turn off the TV and go to bed on time. • Check the mail once per day instead of six times a day. • Volunteer at church.
6. Help the person to exercise his or her own rights and be responsible for the outcomes of their actions on others.	• Get a phone and refrain from calling 911 except in emergencies. • Rent a video and return it on time.
7. Help the person develop a wider base of relationships to extend beyond the service agency.	• Meet others through shared activities. • Learn to date or have a girlfriend. • Spend time with family. • Learn rules of healthy relationships.

Consensus decision making is one way of reaching agreement between all members of a group. Instead of voting and having the majority of the group make the decision,

a team that uses consensus is committed to finding solutions that everyone can agree to. This invites all opinions, ideas, and concerns to be heard and uses the combined knowledge of everyone in the group. Reaching a consensus or agreement is not the fastest or easiest way to make decisions, but it is one of the most respectful. Every member of the group has an equal opportunity to influence the final decision, and every member of the group must agree to carry out the decision even if they have some reservations.

- **Leading Discussion.** Sometimes team leaders need help getting other team members to participate in discussions during the meetings. Team members should look for and respond to opportunities to:

    - Share positive information
    - Affirm others
    - Make suggestions
    - Clarify information
    - Solve challenges

  Person-Centered Planning team leaders may say: "Does anybody have any ideas for how we can support Jack to find a new job?" or "Let's review Charles' plan from last year." These are indirect but important signals that it's time to share positive information.

  Affirming statements bring out ideas that the team needs to explore, "*You talked about a train trip for Charles. That seems like an exciting challenge for him. Would you tell us what you had in mind?"* Affirming statements can also encourage team members to work together. *"That's a good idea! I'd be willing to work with you on that."* Affirming statements also help the team put something that was said with strong emotions into a more positive context. (Example – *"I can see that you care about Jack and want him to be safe.")*

  Affirming statements build trust. Look for opportunities to offer your ideas and draw out the ideas of others; support the work that needs to be done; and acknowledge what is important by reframing what is said in positive terms. This helps the Person-Centered Planning team have meaningful discussions and create close working relationships that result in effective plans.

  It is up to the Person-Centered Planning team members to ask questions when it is not clear what is being discussed. You can help remind the team when jargon is used by asking on behalf of a person receiving support. For example, "Since this is new to Mary's plan, could someone explain what occupational therapy means?" or, "Are long-range goals the same as goals? I'm not sure Mary is familiar with that term."

- **Pivotal Statements.** Team leaders often make statements to keep the team on track. Example: "Let's take about 15 minutes to review progress and talk about strengths and preferences. We'll use these priorities to plan goals and objectives." This kind of statement is sometimes called a "pivotal" comment. The action of the team hinges on what is said. From this statement, the team realizes what it needs to do and how much

time to take. Everyone is invited to participate. Pivotal statements turn the Person-Centered Planning team's attention to important tasks. Effective leaders use these statements to keep the team on track and the planning process flowing, and by asking the right questions, effective leaders can help to minimize storytelling and help teams plan effectively. These questions include:

- **Who is this person we are here to support?**
- **What really matters *to* this person?**
- **What are his or her dreams, nightmares, goals?**
- **What are his or her most important human needs? Or What is important *for* this person?**
- **What do we need to know to support this person?**
- **What happens when this person needs assistance or training?**
- **What are this person's greatest risks in the near future?**
- **How could the person's needs be met?**
- **What would have to change for that to happen?**

Before the Person-Centered Planning meeting ends, all team members need to agree to support the decisions that have been reached. All members must also understand their individual responsibilities for carrying out the plan.

After the Meeting

When the Person-Centered Plan has been put into action the team needs to:

- Ensure all staff (and any new staff throughout the life of the plan) are trained on the plan/updates using clear communication to address any questions/concerns.
- Monitor progress regularly to determine if the person is making progress toward their goals, or if goals have changed for the person. Staff should use the suggestions in chapter 4 to assist the person to review and understand their own progress.
- Revise the Person-Centered Plan as needed. Other than small revisions, changes to the plan can only be made with a team meeting.
- Work collaboratively to assist the person in addressing any barriers to success that are discovered in the data.

Challenges

Many challenges can come up throughout the Person-Centered Planning process. These challenges may occur during meetings or afterward when Person-Centered Plans are being implemented. For example, a staff person leaves the agency, and the new team member doesn't follow the Person-Centered Plan correctly, or the planning was not done well, and no one really likes or understands the plan. When this happens, any concerns, no matter how big or small, should be brought to the attention of a supervisor or the QDDP. The QDDP will determine if the challenge can be addressed with staff retraining, or if a team meeting is needed.

Sometimes the challenges to the plan come from the person supported. You may observe a person making a poor choice. (Example – he or she does not make their bed or eats five pieces of pizza at the party.) Although these choices may not be the best, the person can still achieve his or her goals and the Person-Centered Plan probably does not need to be changed. Other times people make choices that are self-defeating or put themselves in harm's way. For example, staying up most of the night may result in poor work performance, irritability, mood swings, or weakened immunity. If you observe behavior or circumstances that will interfere with reaching the goals identified in the Person-Centered Plan, it is important to act right away without restricting their rights or using force. For example, in the scenario above, provide reminders of possible consequences of staying up late, but still allow the person to make that choice. Be sure to document the challenge and report your concerns to the QDDP. If challenges persist the team may need to meet. When staff don't share their concerns:

1. Other team members won't know about important information that only you know.
2. Good strategies for achieving a goal may be dropped or lost over time.
3. Important changes to the Person-Centered Plan may not occur.

Person-Centered Planning is meant to be a process of continuous improvement. When challenges are not addressed, the person may continue to make poor choices, not understanding the long-term consequences; goals that are important to the person may not be achieved; and the person or team members may become discouraged.

A Direct Support Professional's (DSP's) responsibility for Person-Centered Planning begins as soon as the DSP starts supporting a person. When you provide support to a person, you are a member of their team, whether you attended their planning meeting or not. One of the biggest challenges to Person-Centered Planning occurs when a new person joins the team. It may take some time for a new member to meet the rest of the team, read and understand the Person-Centered Plan, learn how to carry out the Person-Centered Plan and start sharing important information with other team members.

If a review meeting is held, the Person-Centered Planning team talks about the current challenges and any action that is needed. Good performance by the team is recognized and reinforced. In closing the meeting, summarization activities may include:

- Review conclusions and decisions made.
- Check for team members' understanding of decisions and consensus.
- Communicate the plan or any changes with the person receiving services in a way he or she understands.
- Determine whether or not the Person-Centered Plan reflects the person's priorities.
- Review procedures and assign responsibilities for plan evaluation.
- Inform each team member of his or her responsibilities to carry out the plans.

- Evaluate the Person-Centered Planning meeting. Discuss accomplishments first, followed by any suggestions for future meetings.
- Make arrangements for the next meeting if necessary.

Following Up: As a Direct Support Professional, you play an important role in carrying out the Person-Centered Plan. You may be following step-by-step instructions, especially when all team members need to respond in the same way to challenging behaviors. Written procedures may also be used for learning objectives because you may need to provide specific and consistent instruction to a person you support. Other goals may require informal follow-up. This may include visiting someone after a meeting, getting information needed to start a new activity, or helping the person prepare for a change in their life. When you engage with a person you support and communicate that person's preferences, needs, and challenges to the team, you are taking a role in the Person-Centered Planning process. Your contributions are valuable for shaping the Person-Centered Plan as a "living" document - one that empowers the person to improve his or her life and to make plans for the future.

Chapter 5 Feedback Exercise

1. T/F Titles such as Job Coach, DSP, and trainer should be used during introductions at the meeting.

2. T/F Silence can be taken for agreement during a Person-Centered Planning meeting.

3. T/F Consensus decision making is the fastest and easiest way to make decisions.

4. T/F It is important for all team members to participate in the meeting and not just be an observer.

5. T/F It is important to use the least restrictive methods possible when addressing challenges in Person-Centered Planning.

6. T/F There should not be any introductions made at a team meeting.

7. Which of the following does NOT apply when preparing for a Person-Centered Planning meeting?
   a. Get to know the person
   b. Participate in assessments
   c. Ignore the current Person-Centered Plan
   d. Practice a positive approach

8. Which of the following is NOT a value used to guide the decision-making process in Person-Centered Planning?
   a. Help the person achieve outcomes which are important to him or her
   b. Help the person move from dependence toward independence
   c. Help the person move from powerlessness toward having more control
   d. Help the person avoid all responsibilities

9. What should be done if a new team member doesn't follow the Person-Centered Plan correctly?
   a. Ignore the issue
   b. Bring the challenge to the attention of a supervisor or the QDDP
   c. Assume the plan will still work
   d. Make changes to the plan without consulting the team

10. What are three things you can do to look and act as a good role model for others at the Person-Centered Planning meeting.

11. List two strategies you can use to prepare yourself to speak and respond at the meeting.

12. Describe the concept of consensus decision making.

13. What advantages does consensus decision making have over majority rule decisions?

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Feedback Exercise Answer Key

Chapter 1 Feedback Exercise

1. T/F The Citizenship & Advocacy life category involves peer support and self-advocacy.
2. T/F The Person-Centered Plan is a living document that must be reviewed and updated regularly.
3. T/F Person-Centered Planning is only important during the early childhood stage of life.
4. T/F People with disabilities must learn everything that is required to be independent *before* they can live where they want.
5. T/F Setting goals is a key part of self-determination.
6. T/F The core value “Everyone should have choice and control in their lives” focuses on making people into “good workers.”
7. T/F The core value "Learning is lifelong" suggests that people with disabilities can continue to learn new skills and information throughout their lives.
8. T/F Only family members are included in the person-center planning team.
9. What does a meaningful life involve according to the Person-Centered Planning approach?
   a. Living in a place chosen by the person, having relationships with people they enjoy, and choosing how to spend their time
10. What is an example of the core value "Everyone needs support and assistance sometimes"?
    b. Mike gets an automated vacuum to help him do his cleaning. Mike’s staff support him to do less preferred tasks by working alongside him, sharing their attention and making it fun.
11. What are the guiding principles followed by the DD Section of the ND Health and Human Services?
    - Emphasize Person First, with Customized Supports and Services
    - Focus on the Person’s Strengths
    - Balance Choice and Risk
    - Meet the Person Where They Are
    - Regularly Review Goals
    - Build Equity of Voice
    - Equip the Person to Make Informed Decisions
    - Be Kind
12. How does the core value "Everyone is unique" effect program design?
    Programs should fit the person and not the other way around.
13. How should activities be planned according to the core value "Life has many seasons"?
    Activities should be culturally and age appropriate.
14. Why is self-determination important from the beginning of a person’s life?
    Self-determination is important from the beginning because it involves making choices, setting goals, and deciding how one’s own life is lived, which helps individuals lead a meaningful and fulfilling life.
15. What does a meaningful life involve according to the Person-Centered Planning approach?

A meaningful life involves living in a place chosen by the person, having relationships with people they enjoy, choosing how to spend their time, and participating in activities that are culturally and age appropriate.

Chapter 2 Feedback Exercise

1. T/F Learning objectives in a Person-Centered Plan do not need to be measurable.
2. T/F The Person-Centered Plan must be followed as written, even if a team member disagrees with it.
3. T/F The QDDP typically helps plan the meeting and coordinate support when changes to the Person-Centered Plan are needed
4. T/F The Risk Assessment evaluate a person's employment history.
5. T/F The team reviews the Person-Centered Plan at least once per year.
6. T/F The background information (social history) section of a Person-Centered Plan includes information about the person's history and life situation.
7. T/F If a person is not making progress toward a goal, that goal should be removed from the plan.
8. What is the purpose of the Dreams, Nightmares, and Wishes section in a Person-Centered Plan?
   b. To give the team a vision for the kind of life that would have meaning for the person
9. Which of the following is a reason to review a Person-Centered Plan more often than annually?
   d. all of the above
10. What is the purpose of a Self-Assessment in the planning process?
    The self-assessment is required to guide the planning process by revealing the person's preferences, dreams, non-negotiables, and personal goals. It reflects individual outcomes that are unique and specific to the person
11. What should team members do if the Person-Centered Plan is not clear?
    If the Person-Centered Plan is not clear, team members should ask a supervisor or the Qualified Developmental Disabilities Professional (QDDP) for clarification.
12. Why is data collected as part of the teaching plan in a Person-Centered Plan?
    Data is collected to assess the person's progress or lack of progress toward their goals. It helps identify possible barriers to success and methods to support the person around those barriers.
13. Why is it important to follow the Person-Centered Plan as written?
    It is important to follow the Person-Centered Plan as written to ensure consistency in support and to respect the agreed-upon strategies and goals that have been developed for the person's well-being.

Chapter 3 Feedback Exercise

1. T/F The Person-Centered Planning process uses a team approach.
2. T/F Confidential information should only be shared on a "need to know" basis. true
3. T/F The person being supported does not have a choice in choosing their team members.
4. T/F Role exchange involves team members learning from each other to support the person with a disability.
5. T/F Discussing a person's attendance at a day program with your neighbor is a potential breach of confidentiality.
6. T/F Confidentiality is a responsibility shared only by team members that oversee health issues.
7. Which of the following is NOT a benefit of a team approach in Person-Centered Planning?
   c. Teams ensure that only one person is responsible for all decisions.
8. Who is the most important member of the Person-Centered Planning team?
   c. Person being supported
9. What is the purpose of role exchange in the Person-Centered Planning process?
   b. To train a direct support professional to provide specific support and teach the specialist about what works for each person
10. Which of the following **IS** a responsibility of all team members during meetings? Mark all that apply.
    __X__ Be on time
    __X__ Dress appropriately
    _____ Use abbreviations for job titles (i.e., DSP)
    __X__ Respect others
    __X__ Use language that is easy to understand
11. Match each team member with their role.
    a. Direct Support Professional (DSP)
    b. Person Supported
    c. Qualified Developmental Disabilities Professional (QDDP)
    d. Sister
    e. Guardian
    f. Speech Therapist
    __f__ Provide specialized knowledge and support based on the person's needs and preferences.
    __a__ Document daily progress and assist and daily problem solving.
    __d__ Offer support.
    __e__ Make decisions based on the person's wants and needs and how the person chooses to live their life.
    __b__ Chooses who will be part of the team.
    __c__ Assist the person supported to plan and coordinate their meeting.
12. Describe the role of a guardian in the Person-Centered Planning process.
    The role of a guardian in the Person-Centered Planning process is to make decisions based on the person's wants and needs and how the person chooses to live their life. The

guardian's decisions should not be based on their own preferences. Guardians may have responsibilities in specific areas such as financial, medical, or legal decisions.

13. What is Supported Decision-Making and how is it different from guardianship?
    Supported Decision-Making is a less restrictive option that promotes self-determination, control, and autonomy, and fosters independence. It involves the person consulting with trusted people to weigh the pros and cons of a decision. Unlike guardianship, it does not involve appointing someone to make decisions on behalf of the person.

Chapter 4 Feedback Exercise

1. T/F Using complex language is a good way to support people to participate in their Person-Centered Planning meeting.
2. T/F Partial participation is based on the belief that everyone can do some part of any activity.
3. T/F Giving people choice and control is important for the development of self-determination.
4. T/F Using symbols and language that the person can understand is important in the Person-Centered Planning process.
5. T/F Self-assessment is an important tool that puts the person supported at the center of their own planning process.
6. T/F The goal of active support is to manage people and keep them busy.
7. What does the term "engaged" mean when using active support?
   a. Doing things, participating, spending time with others, making decisions, making choices
8. What can be used to help people think about their goals and preferred lifestyle?
   b. Talking about, looking at pictures, or visiting people or places
9. Which of the following is an example of how to help a person understand progress toward their goals?
   d. keep a folder with pictures of their accomplishments
10. What are three ways that people with disabilities can be supported to invite others to their meeting?
    - Meet with the QDDP before the meeting.
    - Look at pictures or names of people.
    - Select people to invite to your meeting
    - Use simple words and clip art to make an invitation to the meeting.
    - Deliver the invitation in person or by email or mail.
    - Use a pre-recorded phone message to send to someone you plan to invite.
    - Set the date. Put a sticker, clip art or date for the meeting on your calendar.
    - View a video to help you remember what happens at a meeting.
    - Ask someone else to take care of these details for you.
11. What is one strategy to help a person share information during their planning meeting?
    - Give the person a signal that it is time to share information
    - Give the person a signal that it is time to share information.

- Assist the person to bring information and ideas in a format he/she can share and understand. For example, the person could share ideas by clicking through the slides in a PowerPoint
- Invite other people who know them well to contribute their ideas and information.
- Explain what other people are sharing or saying about them.
- Talk through how to tell others if they agree or disagree with what is said.
- Put together a collage, scrapbook, or photo diary of key events.
- Use concept maps to display important points about a person

12. What is the goal of active support?
    The goal of active support is to ensure that people, including those with the most significant disabilities, have ongoing support to be actively, consistently, and meaningfully engaged in their own lives.
13. Describe the concept of partial participation.
    Partial participation is based on the belief that everyone is capable of completing some part of any activity. It helps people be actively engaged in their own lives by participating as much as possible in any activity, even if they are not able to do the entire task.
14. What is the purpose of celebrating success in the Person-Centered Planning process?
    Celebrating success is important to acknowledge and reinforce the person's accomplishments, boost their confidence, and motivate them to continue working towards their goals.
15. Explain the importance of providing opportunities for practice in the Person-Centered Planning process.
    Providing opportunities for practice is important because it allows the person to become comfortable with new skills and strategies through repetition, increasing their confidence and ability to participate actively in their own planning process.

Chapter 5 Feedback Exercise

1. T/F Titles such as Job Coach, DSP, and trainer should be used during introductions at the meeting.
2. T/F Silence can be taken for agreement during a Person-Centered Planning meeting.
3. T/F Consensus decision making is the fastest and easiest way to make decisions.
4. T/F It is important for all team members to participate in the meeting and not just be an observer.
5. T/F It is important to use the least restrictive methods possible when addressing challenges in Person-Centered Planning.
6. T/FThere should not be any introductions made at a team meeting.
7. Which of the following does NOT apply when preparing for a Person-Centered Planning meeting?
   c. Ignore the current Person-Centered Plan
8. Which of the following is NOT a value used to guide the decision-making process in Person-Centered Planning?
   d. Help the person avoid all responsibilities

9. What should be done if a new team member doesn't follow the Person-Centered Plan correctly?
   b. Bring the challenge to the attention of a supervisor or the QDDP
10. What are three things you can do to look and act as a good role model for others at the Person-Centered Planning meeting.
    - Use good hygiene
    - Leave T-shirts with slogans at home
    - Wear clothing that isn't revealing
    - Don't use chewing tobacco
    - Don't chew gum
    - Follow the agency dress code
    - Show up 5 minutes early
    - Turn off your cell phone
    - Don't read or respond to text messages,
    - put your phone away during the meeting.
    - Bring a pen/notepad
    - Listen, don't interrupt
    - Take turns
    - Remember to smile
11. List two strategies you can use to prepare yourself to speak and respond at the meeting.
    Think about contributions you can make, write them down and bring them to the meeting.
    Make and bring a list of five key ideas/things that you know are important to the person.
12. Describe the concept of consensus decision making.
    Consensus decision making is a process where all members of the group work together to find solutions that everyone supports or can agree to. It ensures that all opinions, ideas, and concerns are heard and uses the combined knowledge of everyone in the group. It is a respectful way to make decisions, as every member has an equal opportunity to influence the final decision.
13. What advantages does consensus decision making have over majority rule decisions?
    Instead of voting and having the majority of the group make the decision, a team that uses consensus is committed to finding solutions that everyone can agree to. This invites all opinions, ideas, and concerns to be heard and uses the combined knowledge of everyone in the group. Reaching a consensus or agreement is not the fastest or easiest way to make decisions, but it is one of the most respectful. Every member of the group has an equal opportunity to influence the final decision, and every member of the group must agree to carry out the decision even if they have some reservations.


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