PERSON-CENTERED SERVICE PLANNING TRAINING

Trainer Manual

March 2020

Welcome to the AHCCCS Person-Centered Service Planning Training.

Next slide

Introductions

When it's your turn please state:

- Name
- What you do
- Where you work
- What was one thing that made you smile today?

Before we get started, let's do introductions.
Time: 5 -10 Minutes
This exercise may need to be modified depending on your audience. It could also be done by pairing people up and they ask each other these questions (or other questions of your choice), then they introduce each other to the group.

When it's your turn, please tell us:

Your name;
What you do at your job
Where you work
What was one think that made you smile today?

The items to include in your introduction are on the screen as well.

Introduce yourself, then ask who would like to go next.

Thank you!

Next slide

You will find sticky notes on your tables.
Please take a sticky note and write on it one thing you hope to learn as a result of this course.

Give participants up to 3 minutes to write on their sticky notes.

When you are finished writing, please place your sticky note on the "I want to Know" wall chart.

When they are finished placing their notes,
Over the course of our training, you will have the opportunity to check in on your note during breaks. If and when you think you have learned what you hoped to, please move your note to the "Got it Covered" wall chart. Don't worry, I will be reminding you.

At the end of the training, we will review any questions not moved to see if we can provide answers at that point.

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Course Objectives

By the end of this course you will be able to:

- ❖ Discuss the goal of the CMS HCBS Rule and the shift in thinking, process and goal setting for Person-Centered Service Planning
- ❖ Explain the philosophy, values, & principles of Person-Centered Thinking and Planning
- ❖ Identify the strategies, tools and skills used to facilitate a person-centered meeting
- ❖ Describe methods to identify potential goals and developing the "action plan" needed to accomplish them
- ❖ List the roles, responsibilities and expectations of all of the team members

Here are the objectives for this two-day training.
By the end of this course you will be able to:

- ❖ **Discuss the goal of the CMS HCBS Rule and the shift in thinking, process and goal setting for Person-Centered Service Planning**
- ❖ **Explain the philosophy, values, & principles of Person-Centered Thinking and Planning**
- ❖ **Identify the strategies, tools and skills used to facilitate a person-centered meeting**
- ❖ **Describe methods to identify potential goals and developing the "action plan" needed to accomplish them**
- ❖ **List the roles, responsibilities and expectations of all of the team members**

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AGENDA

Day 1:
- ❖ CMS Rules for HCBS
- ❖ Values & Principles
- ❖ Core Concepts
- ❖ Meaningful Conversations
- ❖ Person-Centered Thinking Discovery Tools

Day 2:
- ❖ Person-Centered Service Planning (PCSP)
- ❖ Planning Team
- ❖ Facilitating a PCSP
- ❖ Goal Setting & Developing Outcomes
- ❖ Risk Assessment
- ❖ Informed Consent & Sharing the Plan
- ❖ Action Planning & Implementation

Let's take a look at how we are going to spend the time we have together.

On Day 1 we will cover:

- ❖ **CMS Rules for HCBS**
- ❖ **Values & Principles**
- ❖ **Core Concepts**
- ❖ **Meaningful Conversations**
- ❖ **Person-Centered Thinking Discovery Tools**

On Day 2 you will learn about:

- ❖ **Person-Centered Service Planning (PCSP)**
- ❖ **Planning Team**
- ❖ **Facilitating a PCSP**
- ❖ **Goal Setting & Developing Outcomes**
- ❖ **Risk Assessment**
- ❖ **Informed Consent & Sharing the Plan**
- ❖ **Action Planning & Implementation**

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I want to tell you up front that this will not be a training on how to fill out the new forms.

The forms are only a guide to conducting the service planning meetings using a person-centered approach.

Although we may refer to the forms from time to time, our focus is on person-centered thinking and philosophy.

However, throughout the training, there will be page references on slides that indicate what section of the plan this information will pertain to. The new Person-Centered Service Plan document is in your packet. Go ahead and take it out now so you can look at page numbers referred to throughout the training.

Next slide

This is the foundation of Person-Centered Planning and Thinking:

Everyone:

- **Has a basic right and responsibility to make choices in their life**
- **Need opportunities to find success and independence in community living and employment, regardless of barriers they may face**
- **Need to know about all of the options available and have the skills and/or supports to make informed choices**
- **Have the right to try, whether they fail or succeed, and to try again**

Person-centered practices and planning help people have better lives, not just better plans!

Next slide

Before we begin, let me say that we understand that ALTCS members include people with:

- **Developmental Disabilities**
- **Physical Disabilities &**
- **Chronic Health Conditions**

However, for the purpose of this training, we use "disability" as an umbrella term for individuals requiring this level of care.

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Let's begin by talking about the reason for this training.

The Centers for Medicare & Medicaid Services – CMS – revised their rules regarding how case managers/support coordinators should conduct service planning.

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ALTCS & HCBS

The Goal:

Everyone receiving home and community-based services (HCBS) to have informed choice about:

- Where they live
- Who they live with
- What they do with their time
  - Including who to spend it with and type of employment
- What they do with their resources
- Who provides the services to support the choices that are made

Here is the goal of the CMS Person-Centered Rules regarding Home and Community Based Services.

Everyone receiving home and community-based services (HCBS) needs to have informed choice about:

- **Where they live and who they live with**
- **What they do with their time**
  - **Including who they want to spend it with, and**
  - **The type of employment they have**
- **They need to have informed choice about what they do with their resources, and**
- **Who provides the services to support the choices that are made**

Next slide

CMS Rules on HCBS

Settings must:

- Be integrated in and support access to the greater community
- Provide opportunities to:
  - Seek employment in competitive integrated settings
  - Engage in community life
  - Control personal resources
- Ensure the individual receives services in the community with the same access as individuals not receiving Medicaid HCBS

The CMS Rules regarding HCBS settings say they must:

- **Be integrated in the community and support access to the community**

Members must be provided opportunities to:

- **Pursue competitive employment in integrated settings**
- **Be involved in their community**
- **Have control over their personal resources**

Furthermore, all efforts must be made to ensure the member receives services in their community with the same access as people not receiving Medicaid HCBS.

End of CMS rules on HCBS section.

Next slide

Discontent Leads to Change

Cynical Discontent – Discontent without hope
- Denial
- Distortion
- Departure

Optimistic Discontent - Hope based on trust
- History of action
- Honesty about timeframe
- Progress being made

Where cynical discontent is dominant....trust must be created

The Learning Community For Person Centered Practices

Change only happens where there is discontent. Discontent comes from comparing what *is* with what could be, and there are two kinds of discontent – Cynical and Optimistic.

With every effort for change comes a promise, and where the promise is broken you get cynical discontent. That results in:

- **Denial: This is no different from what we've been doing**
- **Distortion: Perceptions suggest people want what they're already getting**
- **Departure: Passionate people leave when they see no hope for change**

Optimistic Discontent – requires trust based on:
- **A history of l take time**
- **Signs of progress in acting on things that still take time**

Where cynical discontent is dominant trust must be created.

Next slide

When trying to become a more person-centered agency, there are three levels of change:

Level One
Changes don't require permission

- **This results in a positive difference in lives of members or at work**

Level Two
Changes that require permission of organizational leadership, such as:

- **Practices**
- **Structure**
- **Rules**

And these changes result in positive differences in lives

Level Three
Changes in practices, structure and rules made at the system level

- **These changes have an effect on many organizations, and therefore, many people's lives**

The current changes are at level three.

Next slide

Change is Hard

- Some people already doing this type of planning
- Formalize the process - ensure everyone is engaging in a person-centered approach to service planning
- It will take time and adjustment for the whole team

Be patient and open to this process

I know change is hard!
Some people feel they are already doing this type of planning.
This is to formalize the process to ensure everyone is engaging in a person-centered approach to service planning.
It will take time and adjustment for the whole team.
Be patient and open to this process.

The whole point of these changes in the rules and practices is to:

End of Change section.

Next slide

HELP PEOPLE GET BETTER LIVES

Not just better plans…

The Learning Community For Person Centered Practices

Help people get better lives, not just better plans.

This is not about creating better paper

The only reason to do all of this work is for it to make a difference in people's lives.

Remember, any of us may need to utilize long term care services in our lives.

Ask:

Wouldn't you want to be treated in this way?

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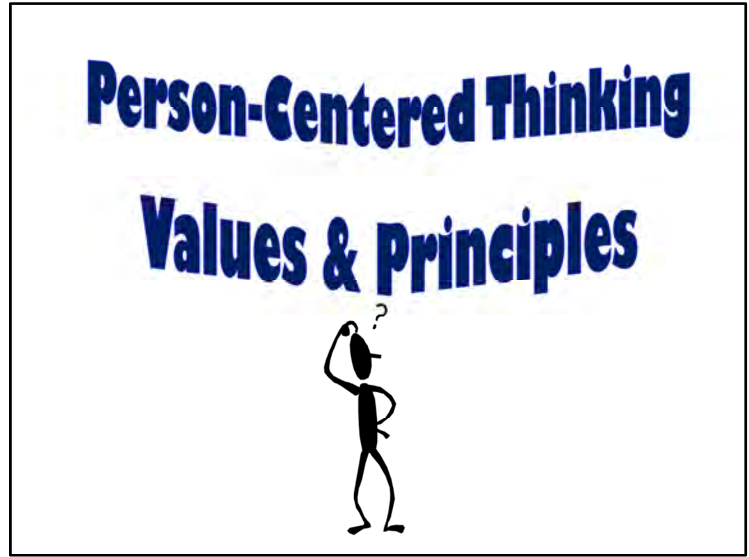


Let's look at some of the values and philosophy of Person-Centered Thinking.

Next slide

What is Culture?

Culture:

- Defines what you think about why things are
  - Right and wrong, good or bad
  - How things are supposed to be
- Is learned and shared knowledge specific groups use to
  - Generate behavior
  - Interpret their experience of the world
- Includes, but is not limited to:
  - Communication
  - Rituals
  - Roles

Ask: **What is culture? What does this word mean to you?**

Our culture helps us define what we think about why things are:

- **Right and wrong**
- **Good or bad**
- **How things "should" be**

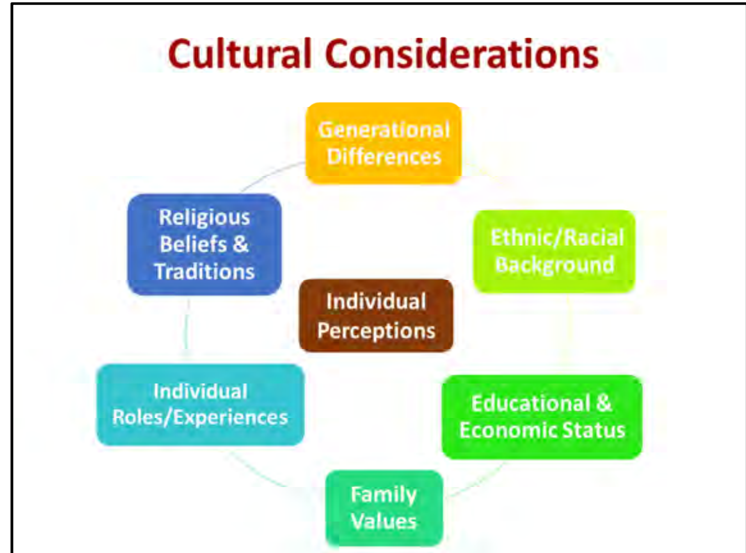
Is learned and shared knowledge that identifying groups use that:

- **Influences our behavior**
- **Helps us interpret our experience of the world**

Includes:

- **Communication**
- **Rituals**
- **Roles we have**

Next slide



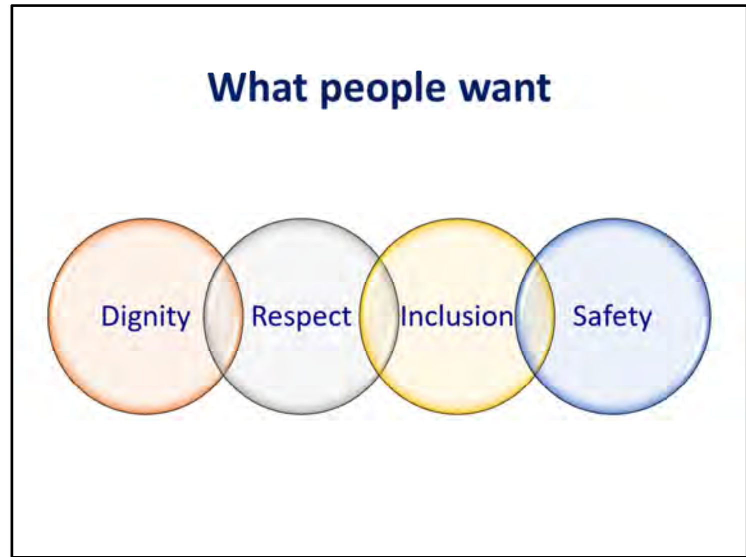
Everyone comes to this work with multiple cultural backgrounds and values that informs each of our individual perceptions of the world.

We need to keep that in mind throughout the process for the member we're working with, other members of the team, and yourself. You all bring your own perceptions and experiences to the table.

This is not an exhaustive list, but these are some of the cultural difference that may be needed to take into consideration when working with anyone.

Review items on the chart.

Next slide



Regardless of our culture, all of us want to be treated with dignity and respect. We want to be included in our family and community and feel safe on our own terms.

These things might manifest differently depending on your culture, but keep these underlying values in mind.

Next slide

Person-Centered Thinking (PCT)

Inspires and guides respectful listening which leads to actions, resulting in people who:

- Have positive control over the life they desire and find satisfying
- Are recognized and valued for their contributions (past, current and potential) to their communities
- Are supported in a web of relationships, both natural and paid, within their communities

The Learning Community For Person Centered Practices

Person-Centered Thinking influences and guide the way we listen and respond to people.

Planning in this way encourages and empowers people to have control over the life they want to live.

It also ensures that people are recognized and valued for contributions to their communities, whether it be past, current and/or in the future.

PCT supports result in a web of relationships, natural and paid, within the communities where people live.

Next slide

Operating Principles

- **Self-Determination**
  Empowerment, personal responsibility, leading the kind of life the person desires
- **Family & Close Relationships**
  Family of choice, support values, community development
- **Inclusion**
  Belonging, engaged in and connected to larger community

The operating principles of Person Centered Thinking are:

- **Self Determination**
- **Family & Close Relationships**
- **Inclusion**

Next slide

Self-Determination

Putting people with disabilities in control of selection of supports & services they receive

- The individual determines what is needed when & who will provide the support
- Shifting of power from professionals to the individual

"Nothing about us without us!"

Self-Advocates define Self-Determination as "putting people with disabilities in control of the selection of the supports and services they receive."

When you encourage the person to advocate for themselves, they determine what is needed, when and who will provide the support.

"Nothing about us without us!" This is really the mantra.

It really has a lot to do with following the lead of the person with a disability, as well as respecting the person's choices – whether you agree with them or not.

Next slide

Self-Determination

- The belief you can take control of your own life
- Is a combination of attitude and abilities that lead to:
  - Setting your own goals
  - Taking action to reach the goals
  - Making your own choices
  - Learning problem solving
  - Taking responsibility for own decisions or actions
  - Experiencing the consequences of making your own choices

What do you think self-determination means?

Take some responses.

Click for bulleted list.
Here are some other aspects about self-determination.

Briefly mention things on the slide that have not been touched on.

Next slide

In Arizona, when someone turns 18, that person becomes an adult who is considered legally competent.

Guardianship is a legal process that must be followed if it's believed that a person may need a legal guardian. A judge makes the final decision if a guardian is needed.

However, just because someone is an adult, that does not mean we ignore the opinions and wishes of the family for an individual over the age of 18.

If the individual would like their family to be part of the team, then absolutely we're talking with them and working together.

On the other hand, if an individual is legally responsible for him/herself, and does not want to include others, including their family members in their decision making process, then respect the individual's choice and decision.

Guardianship is not a decision to be taken lightly. It restricts all of a person's rights. People don't need a guardian just because they make bad decisions – we all have made bad decisions. It should be related to health and safety.

For AZ we have a Legal Options Manual. You can find it on the AZ Center for Disability Law website and the link is in your resource list. The manual lists all of the different types of decision making options that are available. Some power of attorney options, such as assisting with decisions regarding medical, educational, vocational rehabilitation, and behavioral health, only require a signed notarized form. The forms are included in the manual.

Next slide

Self-Determination is actually a civil rights movement led by self-advocates and those who love and support them.

Those who support Self-Determination believe that:

- **Individuals with complex physical needs will not have to tolerate being "housed" in nursing homes at a young age because it is the cheapest way to care for someone with those needs.**
- **No longer will young men & women be required to end their evenings out at 10:00 to be back at the house for change of shift at 10:30.**
- **No longer do individuals need to accept which ever staff member is sent that day by the agency supporting them.**
    - **The individual receiving the support has the right to specify the characteristics desired in a support person, what skills are needed and when and where they are to be delivered.**

These are situations that individuals who experience disabilities have faced just because they happen to have been born with or acquired a disability/chronic health condition.

It has nothing to do with who they are as individuals.

Here is an excerpt taken from Self-Advocates Becoming Empowered, 1996:

"Self-determination is speaking up for our rights and responsibilities and empowering ourselves to stand up for what we believe in. This means being able to choose our friends as well as where we work and live; to educate ourselves and others, to work as a team to obtain common goals and to develop the skills that enable us to fight for our beliefs, to advocate for our needs, and to obtain the level of independence that we desire."

Next slide

Self-Determination

The Center for Self-Determination identifies 5 Operating Principles that define Self-Determination:

1. Freedom to develop a personal life plan
2. Authority to control a targeted sum of money
3. Support to attain personal goals
4. Responsibility for contributing to one's community and using public dollars wisely
5. Confirmation: Getting & staying involved with support & service design and delivery

According to The Center for Self-Determination, there are 5 Operating Principles that define Self-Determination:

They are:

1. **Freedom to develop a personal life plan.**
2. **Authority to control a targeted sum of money.**
3. **Support to attain personal goals.**
4. **Responsibility for contributing to one's community and using public dollars wisely.**
5. **Confirmation: Getting & staying involved with support & service design and delivery.**

The new HCBS rules support these operating principles.

Next slide

Self-Determination

- People motivated by Control Over Choices and Supports
- A shifting of power from the Professional to the Individual
- Professional evaluations have same importance as opinions of the person or their best friend
- Less reliance on paid support staff and more on family and friends
- Family and friends can be as or more vested in the individual's wellbeing than paid support staff

Individuals are motivated by having control over their choices and supports.

Self-determination skills should be taught and learned in real life contexts where the individual is invested in the outcomes, skills, goal setting, problem solving.

You can think of Self-Determination as a shifting of power from the Professional to the Individual.

During planning meetings, the professional evaluation is considered with equal importance as the observations of the individual's needs as told by the person, their younger sibling or their best friend of 13 years.

Whenever possible, there is less reliance on paid support staff that are temporarily part of the person's life and more on the lifelong commitment of family and friends.

There is recognition that family and friends can be as or *more* vested in the individual's wellbeing than paid support staff.

Next slide

Self-Determination & Self-Advocacy

- Speaking up
- Awareness of strengths and needs
- Learning how to get information
- Finding out who will provide support
- Knowing rights and responsibilities
- Problem solving
- Reaching out to others when help is needed

Self-determination and self-advocacy lead the member to:

- **Standing up for themselves**
- **Understanding their own strengths & needs**
- **Learning how to obtain information they need to make decisions**
- **Knowing their rights and responsibilities**
- **Reaching out to others when they need help**

These are skills that need to be learned.

Next slide

Supporting Self-Advocacy

- Don't underestimate abilities of individuals
- Ask for opinions about choices
- Communicate clearly and creatively
- Learn what is important "to" them, not what you think is "good" for them

Supporting self-advocacy requires that we:

- **Don't underestimate the individual's abilities**
- **Continually ask about their opinions regarding choices**
- **Communicate clearly with the member and check for understanding**
- **Take the time to learn what is important "to" them, not what you think they need**

Next slide

Self-Determination/ Dignity of Risk

- Moving away from a safe place, to fully experience the self-respect & self-esteem of being human
- The right to try – including the right to try, fail, and try again

Dignity of Risk is a concept or value that is imbedded in Self-Determination.

One definition is: "Dignity of risk is the moving away from a safe place, in order to fully experience the self-respect and self-esteem of being human."

Dignity of risk is recognizing a person's right to try. That includes the right to try and fail, and the right to try again.

We all learn through experience and some of those experiences may include mistakes.

Ideally the individual is given opportunities to learn while making choices in supported environments with the information necessary to make that decision.

Everyone needs support with decision-making, regardless of guardianship status at some time or other.

Ask: **Think about it, do you seek the opinions of people you trust when facing a decision?**

Next slide

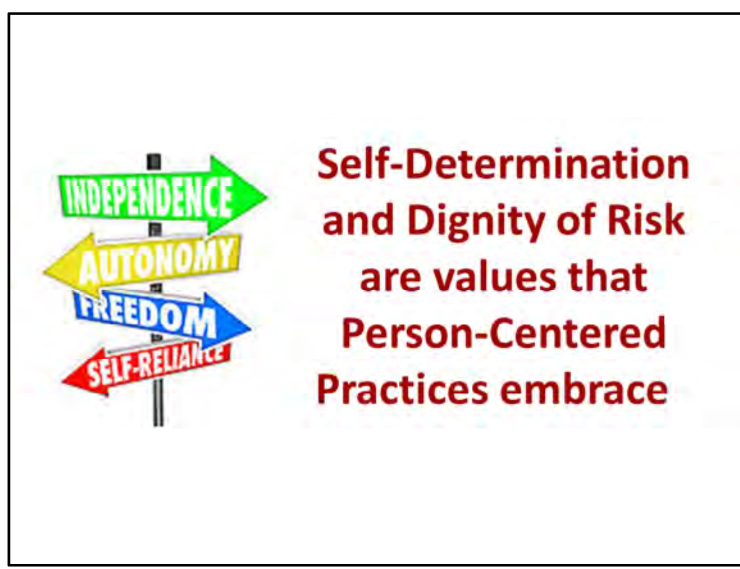
Another way to look at it…

Taking a step backward after taking a step forward is not a disaster, it's more like a cha-cha.

Here's another way to look at it:

Taking a step backward after taking a step forward is not a disaster, it's more like a cha-cha.

Next slide



Self-Determination and Dignity of Risk are values that Person Centered Thinking and Planning embrace.

End of Self-Determination section.

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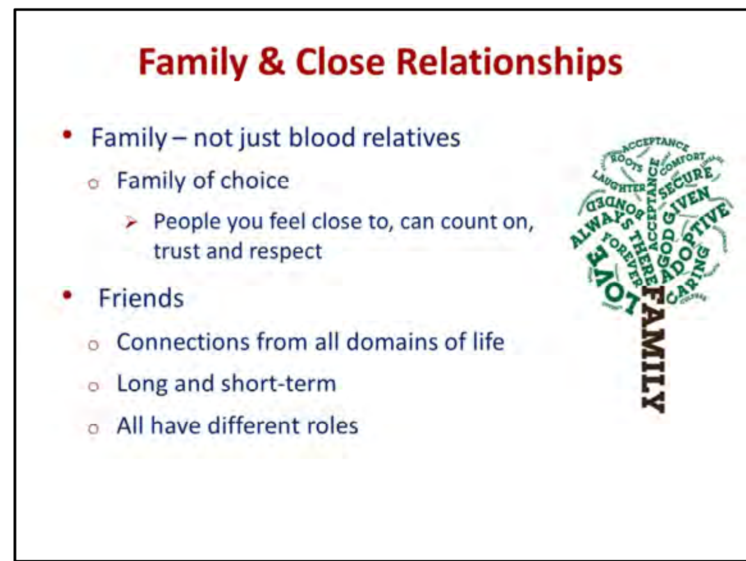

Another operational principle of person-centered thinking is the role and support of Family & Close Relationships.

It's important to remember that family is not just blood relatives, but rather the family of choice. These are the people you can count on, trust and respect

Most of us have friends from various domains of our lives:

- **Home**
- **Community**
- **Work**
- **Spiritual**

Next slide

Family & Close Relationships

- They really know the member best and they:
  - Are invested in the member's success
  - Understand the member's capabilities in different contexts
  - Most likely to know the member's hopes and dreams
  - Can play a valuable role in decision making, advocacy and care

These folks know the member and are invested in their success.

- **Understand the member's capabilities in different situations and roles they play**
- **Most likely to know the member's hopes and dreams**
- **Can play a valuable role in decision making, advocacy and care and should be considered as potential planning team members**

Next slide

Support Values

- Work with people the member identifies being connected with
  - **Potential planning team members**
  - **May be willing to provide non-paid support**
- Be mindful and supportive of the values of group
- Encouraging community involvement can expand the circle of support

Be mindful and supportive of the values in of this group.

The people the member identifies with and is connected to know the member best and likely in different roles and settings.

These are the people who are most likely to provide non-paid support for the member. If you involve others, many people can be helping in little ways.

Work with group to think of ways for the member to become more involved in their community.

Next slide

Community Development

Develop networks through integration of supports provided by:

- Schools
- Churches
- Neighbors
- Community organizations

Encouraging community involvement can expand the circle of support.

Members have many needs which cannot be met through state funded services.

Schools, churches, neighbors, and local community organizations must be integrated with the support provided by family, friends and the support services network.

End of Family & Close Relationships section.

Next slide

How we think about disability

Strengths-based Perspective:

- Look at the whole person as a person first
- Focus on strengths not deficits…never limit someone's potential
- No one is broken and needs to be fixed
- How we refer to and talk about people matters

Person-Centered Thinking principles instruct us to think about disability from a strengths-based perspective.

See the person as a whole person and focus on the strengths rather than deficits. If you don't put limits on someone, you never know what they might achieve.

Nobody is broken. The disability is one attribute of the person and does not need to be fixed.

How we talk to and about people matters.

Next slide

The use of respectful and Person First Language goes hand and hand with that value.

The words we use affect the way we think. What we think influences what we value.

Therefore, how we talk about and to the individuals and their family members is important in establishing and maintaining positive relationships.

As we said before, terminology for different diagnoses have changed over time.

Ask: **What are some of the changes you've heard?**

Possible answers:

- Intellectual or cognitive disability
- Autism spectrum disorder

Next slide

Person First Language

- It's a positive, respectful way of talking about people
- It's putting the person before a label
- By putting the person first, you can convey a positive, objective view of an individual instead of a negative, insensitive image

Ask: **What is person first language?**

- **It's a positive, respectful way of talking about people**
- **It's putting the person before a label**
  - **Maybe not using the label at all if it is not necessary**
- **By putting the person first, you can convey a positive, objective view of an individual instead of a negative, insensitive image**

Ask: **Does anyone have any examples of this?**

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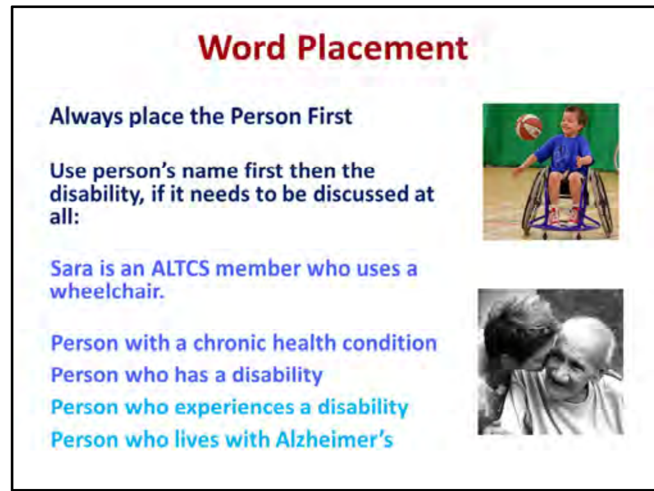

Word placement matters.

Always place the Person First.

Use the person's name first then the disability, if it is necessary to mention the disability.

For example: Sara is an ALTCS member who uses a wheelchair.

If the disability needs to be discussed, here are ways of describing it. You may have been hearing language of people with lived experience, and that is reflected here.
Click for additional phrases

Sometimes it can be condition specific. For example, John is a Traumatic Brain Injury survivor.

Ask: **What is the reason you think we place such an emphasis on this word placement?**

Pause for a few answers. Possible responses:

- I would want to have my name first & my description second.
- It is more respectful that way
- We want to focus on the person, not the disability

Next slide

Here are examples of terms that are not "person first." These are terms to avoid.

What are some examples of alternative descriptions?
Read each one so group can respond with alternatives.

We're handing out some guidelines on how to write about people with disabilities.

Keep in mind that some people practice "identity first" and prefer to be referred to as such. For example, the Deaf Community prefers to use that terminology, as well as do people with blindness. Many people with autism prefer identity first as well. Please don't correct people about how to refer to themselves.

Handout – Your Words, Our Image 8th Edition

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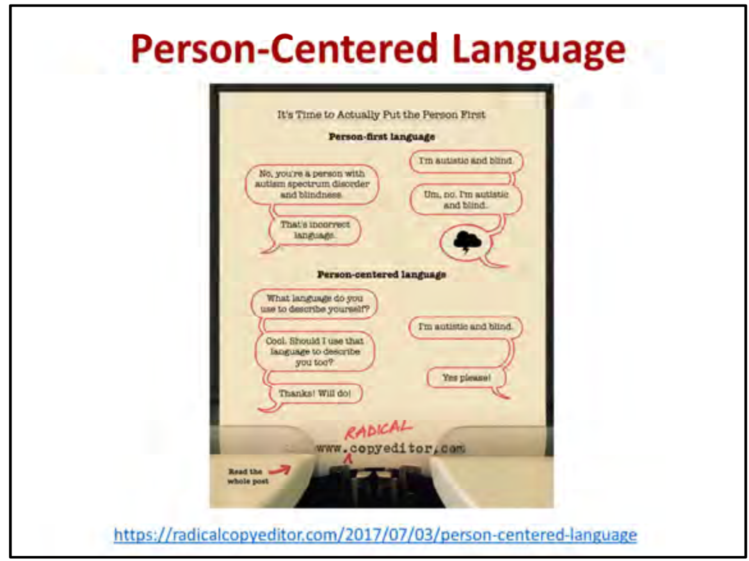


Not everyone puts the word *person* first when they refer to themselves. Everyone has the right to define themselves in whatever term or terms that they feel represents them. The best way to refer to someone respectfully, in terminology that they are comfortable with and relate to, is simply to just ask them.

Ask them how they would like to be described. It will be individualized to their perceptions of themselves.

End of Person-First Language Section.

Next slide

Now we're going to talk about Valued Social Roles.

The way in which individuals are perceived by others is often influenced by the different "roles" they play or have in their lives
AND, conversely,

The "roles" they play in life often influenced the way in which they are perceived by others.

Next slide

Ask: **What are some roles that our society values?**

There are many different valued roles people play.
Click until all pictures populate.

Next slide

Activity Introduction
We're going to do an activity to explore the importance of valued roles.

Divide the group into groups of 3-4 by counting off to 3 or 4 (or more) depending on the size of the group.

I am going to divide you into small groups by counting off by __ (3 or 4). Let's start here.

Point at each person as they count off by the number you indicated based on the size of the group.

Ok, I would like the 1's to meet over here. (Indicate where by pointing.)

The 2's will meet over there. (Indicate where by pointing.)

The 3's will meet over there. (Indicate where by pointing.)

If there is a 4th or 5th group, instruct them where to meet.
Please take your participant guides and something to write with.

Go ahead and move into your groups now.

Give them time to move into their groups as you pass out the flipchart paper (Two (2) sheets per group).
Make sure each group has a dark colored marker (black, blue etc.) as well as red and green marker.

Next slide

Once in their groups,

Each group needs to choose a recorder.

Recorders, raise your hands.

Recorder, select a dark colored marker other than Red or Green.

At the top of the first sheet write "Joe, a person who is homeless":

Click

Now that you have a title for your flip chart page, I want each group to brainstorm a list of words that describe "Joe, a person who is homeless." This is not the time to worry about being politically correct. Write down all the descriptors you've heard or that society would list about people who are homeless.

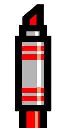
You have 5 minutes to complete this.

When time is up:

Next slide

Good, now let's generate a new list of labels for a movie star, singer or athlete that you think is really great.

Give me a few names and we will vote on one to use.



Write the names given on board or flip chart. Stop after 5 or 6.

By a show of hands find out how many in the class know about each. The one with the most hands is the "favorite important person"
(The activity will be more effective if you can steer the group toward a celebrity who has had some difficulties or public problems as well.)

You may raise your hand as often as appropriate.
Ask: **By a show of hands, how many of you know about/are familiar with**
#1, ____________________?
#2, ___________________?
#3, ____________________?
#4, _____________________?
#5, _____________________?

It looks as if numbers _____ & _____ are your favorites.

Erase the other names or Circle the favorite names.

This time you get to vote only once!
Ask: **By a show of hands again, vote for your favorite famous person.**

How many for #__, ____________________

How many for #__, ____________________

Ok, the famous person for today is __________________.

In your same groups, determine a new recorder.

Or ask for a volunteer different from the first recorder.
Give them a minute to determine their recorders.

Recorders, please write "______, A Famous Person" at the top of the 2nd sheet of flip chart paper using a dark marker (other than red or green).

Just as before, I want each group to brainstorm a list of labels or stereotypes about this famous person, again list things others might think or say or items the news might report or tabloids might publish.

An example might be "rich" or "spoiled".

Keep going around the group until you fill up the sheet or I call time.

You will have 5 minutes.

Ready, Begin.

Start timer for 5 minutes

- Rich
- Famous
- Mother/father

- Son/daughter
- Sister/brother
- Talented
- Voter
- Citizen

Time is up.

Please hang your flip chart paper on the wall next to your first list.

Next slide

Good now let's look at both lists.

Now choose a different recorder.

When they all have a new recorder:

Will the recorder please take a red and green marker and stand by their group's flip chart papers?

Now, please read each label in turn to your group, alternating between the two lists; and by a show of hands the group will decide if it is a positive or negative label.

Circle the positive labels in green and the negative labels in red.

This should be a "no arguing" type of decision, majority rules.

Go through as many as possible in the time period; you will have 5 minutes.

Ask: **Any questions?**

Ready, begin.
Start the timer for 5 minutes.

Time is up! I see lots of color on your lists. We are in the home stretch.

Recorders, enlist the help of a team member and quickly total up the number of positives & negatives in each list.

Write the total number of positives in Green and circle it and the total number of negatives in red and circle that.
Allow time for them to do this.

Ask: **Is there a difference between the lists?**
Group 1, what were the differences in your lists?

Group 2?

Group 3?

Ask Group 4 if there is one.

Go to each group for a brief response.

Ask: **Are there positives on the star's list that could have been on Joe's list?**

Ask 2 groups to respond

Ask: **Are there negatives on Joe's list that could be on the star's list?**

Ask 2 groups to respond

Ask: **What influenced what went on each list?**

Get a few responses.
- You set us up
- It is just that way
- It is the difference in their status in society

You may go back to your seats.

Ask: **Would you consider the thought that it has everything to do with the valued status of the person or group to which they belong?**

Get a response or two, if there are any. It is basically a rhetorical question.

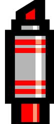
Ask: **Agree or not, does it give you food for thought?**

Another rhetorical question.

You may be asking yourself, what do lists concerning persons who are homeless and famous people have to do with my job working with people with Disabilities?

That is a fair question. Understanding the importance of the concept of valued/positive roles is at the heart of the work you will be doing, regardless of your job title.

Now let's make a new list of your vision of valued roles for individuals with disabilities.



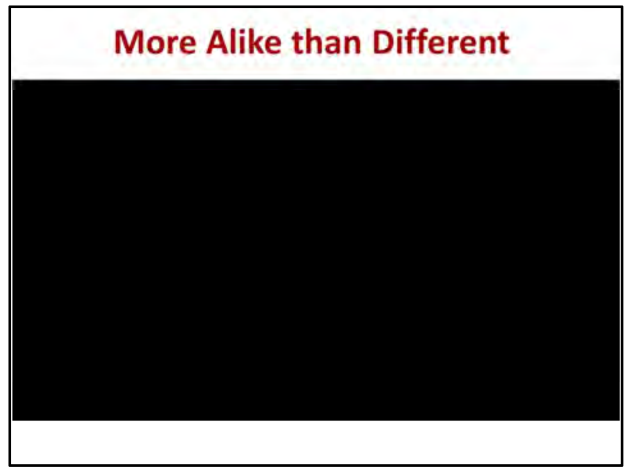
Using a flip chart page, brainstorm as a large group a list until the board or page is full. This list should be much more like the star's list.

- Daughter/son
- Sister/ brother
- Citizen
- Neighbor
- Friend
- Employee
- Worshiper
- Customer
- Voter

If the group struggles with positive roles, give the hint that there are some roles they, might share with the star or all of us.

This is a great list, thank you.

Next slide



Maya Angelou – Human Family
https://www.youtube.com/watch?v=eL_ofpwicsc

We have a video that sums up this section on valued roles.

When finished

Ask: **Reactions to the video?**
Pause for responses.

Next slide

Valued Roles Summary

Person-Centered Practices promote that

- **People with disabilities & chronic health conditions have opportunities in valued roles**
- **Individuals, families and community recognize their many valued roles**

One of the goals of Person Centered Thinking and Planning is to promote people who have disabilities to occupy valued roles and help the individual, their families and the rest of the community to recognize their many possible valued roles.

There's no comprehensive list of valued social roles, but it's easy to recognize a person who has not found one.

End of Valued Roles section.

This may be a good time for a break.
When back –

Next slide

Another operating principle of PCT and Planning is inclusion.

Inclusion means that the people who have disabilities are connected and belong to the larger community.

Therefore, they are engaged in and a contributor to the community of choice.

The ideal would be for all communities to practice the concept of "universal design." This means that environments, learning, products, etc. are accessible to everyone, with or without disabilities.

This image says it all –
The Values of Inclusion:
Everyone is born in
All means all
Everybody needs to be in
Everybody needs to be with
Everyone can communicate
Everyone can learn
Everyone is ready
Everyone needs support
Everyone can contribute
Together we're better

Next slide

People with disabilities face some common barriers to participation are:

Attitudinal

- **Stereotyping**
- **Lack of insight regarding access and participation**

Communication

- **Information not being offered in various formats**
- **Using language that isn't understandable**

Physical

- **Steps, curbs etc. that impede access**

Policy

- **Denying qualified people from opportunities to participate**
- **Denying reasonable accommodations**

Programmatic

- **Insufficient time set aside for medical appointments**
- **Provider's attitudes**

Social

- **Low number of people with disabilities who are employed**
- **More likely to live in poverty because of reliance on benefits**

Transportation

- **Lack of accessible or convenient transportation to enable people to be more independent**

Next slide

Another important value in person-centered thinking relates to least restrictive and integrated or inclusive supports.

Ask: **When you hear "least restrictive," what comes to mind?**
(Validate answers)

- Less is more
- Just enough
- Not too much, not too little
- Just right

Another way to think about "Least Restrictive" is "Just Enough". Not too much, not too little.

This reminds me of Goldilocks in the 3 Bears house when she said, "This porridge is too hot, this one is too cold, but this one is just right."

Next slide

Least Restrictive Supports & Level of Needs

Applies to:

- Amount of physical assistance
- Where the individual lives & works
- Amount of support

Least Restrictive Supports can apply to everything from how much physical assistance to give a person to where the individual lives and works.

Next slide

Least Restrictive Supports & Level of Needs Activity

Instructions:

1. Find your assigned group
2. "Go" = place cards in envelope in order from highest level of need or most restrictive support to least
3. Finished = Shout out your category to receive number

Divide the class into 4 groups. If you have large numbers, have duplicate copies so there can be more than 1 group doing a category.

I am passing out envelopes to each team that I want you to leave closed until I give you the ok to open them.

Each group will receive an envelope of activity cards & pieces of tape (one for each card). Using either wall or floor space for each team to place the cards in order from highest level of need or support to least.

Inside your envelopes, you have cards with short scenarios on them. Your mission is to place them on the table/floor in order from highest level of need or support to least level of need or support.

This activity is created to facilitate conversation about what these different categories mean when talking about members' quality of life. There are not necessarily any right or wrong answers, so we will talk about how you made your decisions.

Next slide

Clarification of Categories

- **Living Options** – Rate level of placement in terms of most restrictive to least restrictive setting
  - Also consider independence
- **Eating Supports** – Rate according to level of support needed
- **Mobility** – Rate according to level of support and independence
- **How They Spend Their Day** – Think about level of need & service as well as how integrated they are in their community

Be prepared to discuss your decisions.

Here's some further clarification for the categories you have:

- **Living Options – Rate the level of placement in terms of most restrictive setting to least restrictive setting, also thinking about independence.**
- **Eating Supports – Rate according to level of support needed.**
- **Mobility – Rate according to level of support and independence.**
- **How They Spend Their Day – Think about level of need & service as well as how integrated they are in their community**

When you are finished placing them in order I want you to shout out the category you've worked on and sit down.

Be prepared to discuss how you made your decisions about the order.

Any questions? Go!

Ok, we have one group that has finished, keep working until you have your cards in the order you think is correct.

It looks like every group has finished. Let's go over what order you all chose. I want to remind you that these examples are listed to make you think about the concept of least restrictive supports, and that everyone may place things in different order depending on their viewpoint and experience. We want to discuss how you came to your answers.

Next slide

Living Options -
Most Restrictive to Least Restrictive
(Also Consider Independence)

- Richard lives in a nursing facility and shares a room with Steve because that was the only empty bed. There are rotating staff 24 hrs. per day.
- Sam lives in a group home operated by an agency of his guardian's choosing. He has his own room decorated with his favorite things. He and his housemates attend different day programs because they have different interests.
- Pablo lives alone in an apartment in an assisted living center. He fixes his own breakfast and lunch, but has dinner downstairs in the dining hall. A nurse comes by daily to make sure he takes his insulin.
- Michelle has physical needs that require supports in the area of transfers, dressing, bathing, meal preparation and eating. Her caregiver is her sister who lives next door. She can be alone at night when she has access to her phone to request assistance, when needed.
- Betty lives alone in her own home. She has a provider come in 3 times a week to assist her with bathing and housekeeping.
- Debbie lives with her granddaughter's family. Her granddaughter uses the service of a respite provider on occasion when Debbie does not want to go where the rest of the family is going.

Go to the group that did Living Options and ask them,

Living Options, what is the order of your cards?
After the group reports the order they've placed the examples in:

Let's talk about your order.
Click to reveal the order on the slide

Compare the group's ranking to the ranking on the slide. If they don't match ask the group to explain how they decided upon the order. For example, "What made you decide that this one was more restrictive that that one?"
Talk about their rationale.

You can ask the other groups if they agree with the order the group came up with. If there is disagreement, talk it through with the group.

Next slide

Eating Supports
Level of Support Needed

- Fred receives all of his nutrition & fluids through a gastronomy tube that was placed into his stomach surgically.
- Maria eats soft blended foods for 2 meals per day and receives her liquid meal during lunch at school through her gastronomy tube (G-tube) and overnight via the pump attached to her G-tube.
- Nicole's food is cut up into pieces no larger than ½ " to prevent her from choking. In addition, someone must be present when she is eating.
- Juan is able to use his fork and spoon to eat his meals. He needs some support using his knife when the meat he is cutting requires much pressure.
- Christina gets one hot meal delivered to her home daily.
- Teri's sister leaves labeled meals for dinner in the freezer for her to heat using the microwave based on the color coded menu on her fridge. Teri needs no other mealtime supports.

Go to the group that did Eating Supports and ask them,

Eating Supports, what is the order of your cards?
After the group reports the order they've placed the examples in:

Let's talk about your order.
Click to reveal the order on the slide

Compare the group's ranking to the ranking on the slide. If they don't match ask the group to explain how they decided upon the order. For example, "What made you decide that this one was more restrictive that that one?"
Talk about their rationale.

You can ask the other groups if they agree with the order the group came up with. If there is disagreement, talk it through with the group.

Next slide

Mobility
Level of Support and Independence

- Sally's caregiver uses a mechanical lift on a track to safely move her from her bed to the bathroom. When lifting her at times where there is no lift, a two person lift is needed.
- Ted is able to bear some weight on his feet so his dad is able to transfer him easily from his wheelchair to any other surface.
- Sue has been wearing a Gait Belt (a thick, strong belt) when standing or walking for support for staff and family members to hold on to so she doesn't lose her balance.
- Felicia uses her walker indoors for stability when getting in and out of chairs or walking distances greater than 100 feet.
- Jason uses an electric wheelchair and is able to transfer independently.
- Since breaking her hip, Abby uses a cane for stability.

Go to the group that did Mobility and ask them,

Mobility what is the order of your cards?
After the group reports the order they've placed the examples in:

Let's talk about your order.
Click to reveal the order on the slide

Compare the group's ranking to the ranking on the slide. If they don't match ask the group to explain how they decided upon the order. For example, "What made you decide that this one was more restrictive that that one?"
Talk about their rationale.

You can ask the other groups if they agree with the order the group came up with. If there is disagreement, talk it through with the group.

Next slide

How They Spend Their Day
Level of Need/Service &
Integration in Community

- Frank lives in a nursing home and plays bingo and paints during the day
- Millie goes to an adult day program 5 days a week
- Felicia attends work-readiness classes 5 days a week through Vocational Rehabilitation
- Jorge volunteers at the local chapter house 3 days a week.
- Clive has a job working tribe part-time and receives physical supports related to mealtime and using the restroom in the job setting.
- Rita works stocking shelves at the Bashas' grocery 3 days a week

Go to the group that did How They Spend Their Day and ask them,

How They Spend Their Day, what is the order of your cards?
After the group reports the order they've placed the examples in:

Let's talk about your order.
Click to reveal the order on the slide

Compare the group's ranking to the ranking on the slide. If they don't match ask the group to explain how they decided upon the order. For example, "What made you decide that this one was more restrictive that that one?"
Talk about their rationale.

You can ask the other groups if they agree with the order the group came up with. If there is disagreement, talk it through with the group.

After all the categories have finished summarize what happened.

Next slide

Least Restrictive
Supports & Level of Needs

The goal for each person is to offer the amount of support necessary for a person to be successful

Just Enough

The goal for each person is to offer the amount of support necessary for a person to be successful.

Each person's strengths and needs are unique, and abilities vary from one domain to another.

One person may need to be fed, while another might just need to have food cut into small bites.

Environmentally, some individuals may need to live somewhere where all sharp objects - such as knives and scissors - are locked to prevent the person from hurting themselves, while others live where they have free access to knives for cooking and scissors for household tasks.

Some may asks for help ordering food when in a restaurant when he/she needs it; otherwise, those who support them wait for them to make known what they want from the restaurant staff.

The level of support needed is different for each person.

Next slide

Ask: **What does Integrated/Inclusive supports mean to you?**
Take responses

When we use the term "integrated/inclusive" supports, we are talking about supports to people within their community.

Ask: **What are some examples of community activities that are inclusive?**
Take responses
Examples:
- Local bowling league
- Meet up group for crafting or book club
- Special Olympics Unified Sports

It is the right of all individuals, including those experiencing disabilities, to have opportunities for participation, membership, and friendship within the community.

Next slide

For working age members, we must always consider employment first.

- **Be sure to discuss employment with those members because people with disabilities can work.**
- **There are many benefits to employment for all of us, and these are just as important to the people we serve.**

We understand some have elderly members who won't want to or are not able to work.

- **People like to be helpful, feel useful regardless of age**
- **Explore meaningful ways for them to spend their days**
- **You might consider volunteerism**

Next slide

Person Centered Practices embrace the value of Least Restrictive and Inclusive Supports

AND

Strive to promote this value to improve the lives and experiences of individuals who have disabilities and chronic health conditions

Person Centered Thinking and Planning embrace the value of Least Restrictive and Inclusive Supports and strives to promote this value to improve the lives and experiences of individuals who have disabilities.

End of Least Restrictive and Inclusive Supports Section.

Next slide

Person Centered Practices support empowering individuals to have autonomy and independence in their lives.

Next slide

Choice & Control

Choice is not just about preferences.
Having choice with control is how we:

- Give purpose and meaning to our lives
  - Creating our unique definition of being fulfilled
- Develop and maintain reciprocal relationships that sustain us
- Create our own supportive environments
  - Preserve the practices that reflect our culture
- Manage our day to day lives so we have
  - More moments that make up good days
  - Fewer moments that make up bad days
  - Can cope when we experience loss or have a bad day

Smull, 2017
https://tlcpcp.com/docs/choice-and-control

Having choices is not just about preference.
Choice with control is how we:

Give purpose to our lives

- **Creating our unique definition of being fulfilled**

Develop and maintain reciprocal relationships that support and nurture us

Create our own supportive environments

- **It helps us to preserve the practices that reflect our culture**

Manage our day to day lives so we have

- **More moments that make up good days**
- **Fewer moments that make up bad days**
- **Can cope when we experience loss or have a bad day**

You can find Michael Smull's paper about Choice and Control at the link on the slide.

Next slide

Ask: **How do we help members to gain control over their lives?**
Pause for responses

It requires us to understand:

- **What a person wants**
- **Where they want it**
- **When they want it**
- **Why they want it**
- **How they want it**

Person-centered service planning helps us to get the answers to those questions.

Next slide

How We Gain Control Over Our Lives

People's decisions based on **choices** they make:

- Choice – Not picking between two options
- Choice – Has limitations and impact (understanding them)
- The person must find the options appealing to them

CHOICES

Our decisions are based on our choices, but:

- **Making a choice is not just picking between two options**
- **All choices have limitations and impact and the person needs to know what those are**
- **They aren't really choices if the person doesn't find the options appealing**

Next slide

Choice Has Balance and Boundaries

As we think about choice, we see:
- All choice can be irresponsible
- Dictating lifestyle is unacceptable

Good support means finding the balance
- Finding the balance can create conflict
- **We all have a right to make choices, even *bad* choices**

The Learning Community For Person Centered Practices

Choice has balance and boundaries.

All choice can be irresponsible, but others dictating lifestyle is unacceptable.

Balance can be achieved with good support. However, finding the balance can create conflict.

We all have a right to make choices, even bad choices.

Ask: **We've all made bad decisions haven't we? Did we learn from our mistakes?**

Next slide

Choice Has Boundaries for Everyone

- Imposed by society
  - Laws
  - Expectations/values
- My Values
  - What is and is not OK for me and those I trust
- Ripple effect – One choice creates boundaries
  - My relationships
  - The work I do
  - Where I live

When speaking of choice, there are boundaries for everyone:
Some are imposed by society

- **We have laws we all have to abide by**
- **There are expectations/values imposed by the community and/or by our culture**

We all have personal values

- **What is and is not OK for me and those I trust**

Our choices can have a ripple effect – a choice may create boundaries

- **My relationships**
- **My work**
- **Where I live**

The difference is when the boundaries are set for the convenience of the system, the result may be limiting choices that meets the person's desires:

- **Operation hours**
- **staff available**
- **policies or procedures.**

Next slide

Sometimes our choices are limited because of our resources or lack thereof.
Sometimes they involve too much risk.
Then there are cultural boundaries that may influence our choices due to our values.

Next slide

Informed Choice

Supporting people in having informed choice requires that:

- The person knows what she or he wants,
- The person knows what is possible, and
  - What is possible includes what is desirable
- The person knows and understands the risks and "trade-offs" and has been assisted in finding the best balance among them

To have informed choice requires that the person

- **Knows what they want**
- **They know what is possible**
  - **Which includes what is desirable**
- **But they also must understand the risks and trade-offs involved**

Many members have had limited life experiences and will require a structured discovery process in order to acquire the skills needed. Many may need opportunities to try new things, take some risk, and learn from mistakes.

Next slide

This activity can be done either by revealing each choice and taking a show of hands, or giving participants a chance to write things in their workbook.

To understand more about decision making, let's think about how we make decisions.
Click
Ask: **Do you jump right in?**
Click
Ask: **Ease into it?**
Click
Ask: **Consult others?**
Ask: **Who do you talk to when trying to make an important decision?**
Click
Ask: **Avoid it?**
Click
Ask: **Weigh the pros and cons?**

As you can see, we all have different ways of approaching decisions.
Click

Ask: **Do we know the answer to this question for the members we support?**

Discussion can occur after the last question reveals itself.

Next slide

Types of Decision Making

Informed Decision Making
- Decision maker understands: options, outcomes, potential consequences

Substituted Decision Making/Guardianship/Surrogacy
- Legal appointment
- Due to impairment

Supported Decision Making
- Person receives help to understand situations and choices so they can make an informed decision

There are different types of decision making as well.

Informed Decision Making
Most of us use this to come to a decision.

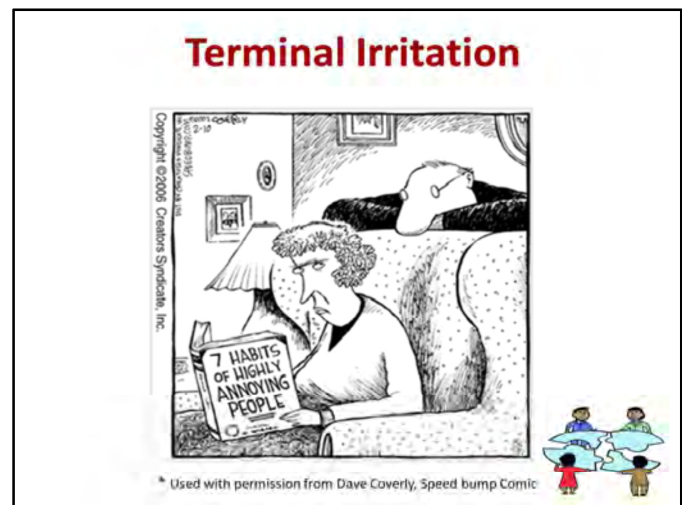
- **Discovery of options comes from using outside sources and our own experiences to uncover possible outcomes and potential consequences**

Substituted Decision Making
Decisions are made by someone else

- **Legally – parents, guardians or court ordered power of attorney**
- **Someone might be making decisions on behalf of person because of impairment**

Supported Decision Making
The person receives help to understand options to make an informed choice.

Next slide



Be sure to have flip chart papers, one for each question with the question at the top, up on the wall to record answers to the following questions:

1. What really annoys or irritates you?
   A. 2 sheets may be needed
2. What do you do?
3. What do you do? (response to you are not in charge of where you live right now)
4. One Year Later…
5. Five Years Later…
6. What would it take to trust?

Record participant answers on the corresponding flip chart paper.
Allow 20-60 minutes (depending on time available for discussion).

Ask: **What is one of your pet peeves, or something that others do that just sets you off?**
Record answers on flip chart paper. Encourage people to share until the group begins to run out of items.

Ask: **So if someone is doing that, what do you normally do to show how you feel?**
Record answers on flip chart paper

Imagine you are now living in a place where all of these things happen. (Read some of the items they have listed)

All of these behaviors are present, and even the ones you thought about and didn't say. However, you cannot leave this place, you have to stay. You are not in charge of where you live right now.

Ask: **Think about how you would feel, *then tell us what you would do* to show other people how you feel?**
Record answers on "What would you do?" sheet. If participants list feelings, redirect to what they would *do.*
Review the responses with the group.

Here is how the system generally responds to those behaviors:

- **People who are aggressive get to move, but to someplace where what irritates them happens more and where they have even less freedom and more people are there;**
- **People who run away are caught and move to the same place that the aggressive people have moved to, it is a place that is locked;**
- **People who scream, are "non-compliant", etc. get a behavior program where something that is important to them is taken away and they have to earn its return by not screaming, but there is no other change;**
- **People who are passive get ignored (and we will call it their choice)**
- **People who withdraw get a socialization program, or one-to–one staff attention with a staff member who is particularly irritating to them; and**
- **People who try to please get praised but still have no change in the behaviors they have to tolerate**

It is now a year later and nothing has changed. The behaviors that irritate are still present, and you have a "program." No one has acted on your distress except as was just described.

Ask: **Think about how you feel NOW, and tell us how you would behave? What are you doing? Again, remember we want to know how you feel and not how other people would feel, and we want to know what you are doing that lets others know how you feel."**
Recorder writes down their responses (on the "One year later" sheet).
Review them with group applying the same system logic as before.

"It is now 5 years later. The behaviors that irritate and annoy are still going on. But now someone comes and does a person centered plan with you. This person is truly gifted at listening and hears what you are saying with words and behaviors. The planner hears your distress and captures it on paper. The plan is reviewed with you and you discover that it not only describes and explains exactly what irritates and annoys you, but also says what needs to change so that these behaviors will no longer be part of your life. After this remarkable experience, the planner leaves, giving the plan to the facility manager on the way out. The facility manager says, "Just what I needed for the people from licensing who are coming next week." The manager then puts the plan in a file, but nothing really changes, everything goes back to the way it was.
Ask: **Now how do you feel? What would you do?**
Write responses on "Five years later" sheet.
Emphasize the themes on the sheet.

Ask: **Who are you angrier with, the planner or the manager? Why?**
Facilitate a brief discussion around their answers.
Possible responses:

- Expect things like, the manager always acted that way - not a surprise
- Planner got my hopes up and the let down was harder, etc.

Be sure to make the point, there is no right answer, everyone will feel

betrayed and let down, who they focus this on doesn't change their feelings.

This is a place like those found in the soap operas.
The first planner was actually the evil twin of the real planner.

- **The manager attended a person centered thinking training**
- **Has had a life changing realization that what they do at their work must change**
- **The manager comes back ready to implement the plan**
- **The planner is eager to make the changes and is happy the manager has seen the light**

Ask: **Now what will it take for you to trust them?**
Record responses on "What would it take to trust" sheet.

Click to next slide for discussion

Let’s talk a little about this interesting exercise.
Click
Ask: **How did you feel during this exercise?**
Possible responses and points to make:

- See what the effects of being powerless and not listened to would be in their own lives (and see the effects on other people who are also not labeled)

Click
Ask: **How does this relate to people receiving supports?**
Possible responses and points to make:

- Behaviors and “symptoms”, including hitting other people, breaking things, withdrawal, and being desperate to please may be a response to years of not being listened to and being powerless, or not having trusting relationships
- A person centered plan is a promise and that plans that are developed but not implemented represent a betrayal of trust

Ask: **Does it give you a better understanding of some of the behaviors you may see from the people you work with?**

End of Choice & Control Section.

Next slide

Person-Centered Thinking Skills

A set of skills that reflect & reinforce values that:

- Propel the learning cycle
- Help us support rather than fix
- Work for humans
- Work at every level in the organization
- Build the culture of learning, partnership, and accountability
- Affirm our belief that everyone can learn

The Learning Community For Person Centered Practices

In summary, Person-Centered Thinking Skills are a set of skills that reflect and support values that:

- **Drive the learning cycle**
  - **You are constantly learning new information and discovering new paths to explore**
- **Help us to support rather than fix**
- **Work for humans and at every level in the organization**
- **Create a culture of learning, partnership and accountability**
- **Affirms and reinforces our belief that everyone can learn**

Next slide

Remember

- **This is not about creating better paper.**
- **The only reason to do all of this work is for it to make a difference in people's lives.**

Next slide

Core Concept & Skill of PCT

Identifying what is:

- Important ***to*** the person
- Important ***for*** the person

The most important principle of PCP is identifying what is

- **Important to the person**
- **Important for the person**

Ask: **What do you think is the difference between these two?**
Pause for responses.

Next slide

Important To

What is important to a person includes those things in life which help us to be satisfied, content, comforted, fulfilled and happy. It includes:

- People to be with /relationships
- Status and control
- Things to do
- Places to go
- Rituals or routines
- Rhythm or pace of life
- Things to have

The Learning Community For Person Centered Practices

Important to includes the things in life which help us to be fulfilled, satisfied, comforted, and happy. That includes:

- **Our important relationships**
- **Having status and control**
- **Things we like to do and places we like to go, things we like to have**
- **Our rituals and routines that bring order and predictability to our lives**
- **Our preferred rhythm or pace of life**

Next slide

Important To

What matters the most to the person – their own definition of quality of life (even if other's don't agree it should be)

What is important to a person includes only what the person is "saying":

- with their words
- with their behavior

When words and behavior are in conflict, listen to the behavior and ask why

The Learning Community For Person Centered Practices

These are the things that matter most to the person.

Emphasize - **this is about all humans not just about people with disabilities**

What is "important to" includes only what the person is "saying" is important either with words or their behavior

Ask: **How many of you are living with another adult?**

Select 1 person and ask them
Is your partner's behavior ever at odds with what they say with words?

Ask: **"When what they say is different from what they do - which do you listen to, words or deeds?"**

Hopefully the person will answer – "deeds" – so we already know that we should listen to behavior

When we do not trust people we are hyper-vigilant about what they do much more than about what they say.

For people who use long term care services -
We often need to look at behavior because we have done a really good job of training people to tell us what we want to hear.

When people don't use words to talk, we have to listen to their behavior, and ask why.

Possible example

Ask: **If you were working with someone who needed insulin injections but hated them and the finger sticks that go with them – would diabetes management be important to or important for?**

Next slide

Important For Includes

Issues of Health	Issues of Safety	What's Necessary to Help Person
• Prevention of Illness • Treatment of illness/medical conditions • Promotion of wellness (e.g.: diet, exercise	• Environment • Well being – physical and emotional • Free from fear	• Be valued • Be respected • Be a contributing member of their community

While "important for" includes issues of health and safety, it also includes those things that we are paying attention to in helping the person be a valued member of their community.

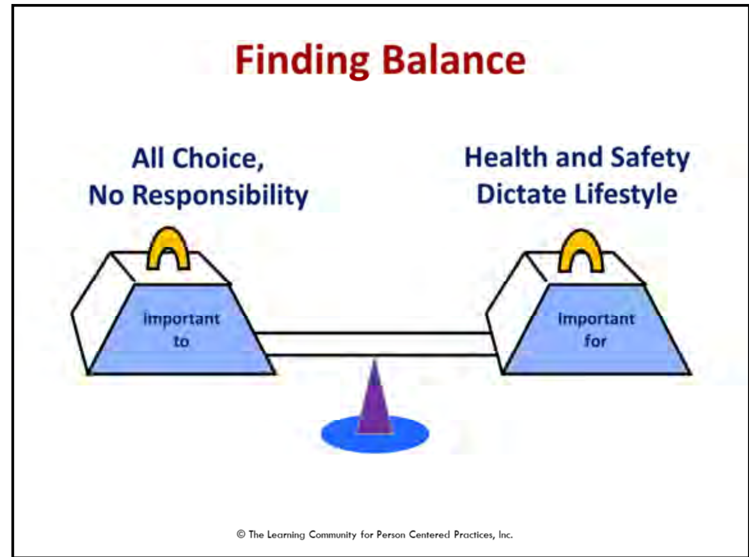
Illustrate with a brief story like this –

You are working with someone who dresses appropriately for the weather, you show-up to take them to a job interview during the summer and they are wearing a tank top, running shorts and flip-flops.
Ask: **Do you say something or just take them to the job interview?**

TIPS:

It never hurts to use humor – ask how many people have teenagers at home, then ask if they have ever said to the teenager "Where are you going dressed like that?" Point out that the teenager is dressing to be a valued member of their teen community while the parent is asking them to dress to be a valued member of the larger community.

Next slide



One of the mistaken assumptions about PCP is that we only listen to what is "important to" and ignore what is "important for."

We all have examples of where "it was their choice" was used as an excuse – but we don't want to set people up to be hurt.

It's about:

- **Informed choice**
- **Providing one with the information and supports necessary to make an informed decision regarding the risks associated with their behavior**

Balance is what everyone seeks in their own lives, and it's not always easy.

When our lives feel out of balance we look to see what we can change to get a better balance.
It's always shifting.

Again the emphasis is on balance. There are 3 challenges:

1st is to discover what is *important to* each person,

2nd is to help those providing the support find a balance between to and for.

3rd, keep in mind that finding a balance is also about tradeoffs.

Don’t forget, having what is ‘important to’ relates to being healthy and safe as well.

When things that are important to you are missing, we often act in ways contrary to what is important for us.

Next slide

Important *TO* and *FOR* are Connected

- Important to and important for influence each other
- No one does anything "important for" them (willingly) unless a piece of "important to" is present
- Balance is always changing and always involves tradeoffs:
  - Among the things that are "important to"
  - Between important to and for

It's not about being Happy OR Healthy, Satisfied OR Safe
It's about being Happy *AND* Healthy, Satisfied *AND* Safe

The Learning Community For Person Centered Practices

Learning about what is "important to" the person first is critical

Most people won't do anything" important for" them unless some part of "important to" is involved.

- ***Important to*** **is needed to create buy-in**
- **Maintaining a balance is always changing and involves tradeoffs between the two**

Health, safety, valued social roles should be considered in the context of what is important TO.

It's not about being Happy OR Healthy, Satisfied OR Safe.
It's about being Happy AND Healthy, Satisfied AND Safe.

We don't want health and safety without considering what creates happiness and fulfillment to the person.

Next slide

Finding a Balance

- We all make tradeoffs between different things that are *important **to*** us
- We also make tradeoffs between what is *important **to*** us and what is *important **for*** us
  - Tradeoffs can be temporary OR long term solutions

The Learning Community For Person Centered Practices

Click & read each bullet as they appear
ASK for examples from participants for each statement.

Provide examples if struggling:

- Tradeoffs – important to us
  - Some people love living in a particular place
    - Are willing to make tradeoff when living there means a longer commute to a job they love
  - Spending time with friends or family
  - Buying something expensive

- Tradeoffs – important to and important for
  - Fun time with friends may be important
    - Having a clean house part of being valued by friends
    - House cleaning may come before having fun with friends
  - Expressing personal opinions and saying what’s on his mind important to
    - Not cussing in front of neighbors may be important for him
  - We may love to eat good food but know it will cause heartburn later
  - Like to sleep in on the weekends, but will get up early to hike with a friend

Next slide

Sorting Important to from Important for
(and finding a better balance between them)

Important To	Important For

What else do we need to know/learn?

Lets have some practice sorting out Important to and Important for. Find this handout in the activity section of your packet and try to figure these out for yourself.
Give 5 minutes

Ask: **How was that for you?**
Take some responses.

Finding out the information for this tool is often not as simple as asking the person. You will glean this information from what you learn with the discovery tools.

Being able to see what is *important to* people and separating it from what is *important for* is the fundamental skill, *and is probably the most important guiding concept in person-centered planning.*

Next slide

Now we're going to talk about Julie's story. You can find it in the "Stories" section of your booklet.

Next slide

	What works/makes sense	What doesn't work/make sense
Julie's perspective	• Shopping for favorite things • Having lots of jewelry and no one getting into them without my ok • Having my sister Joanne in my life • Lots of blue, red and black clothes • Polished nails, many colors & layers • Living with Teddy, the Yorkshire ⇨ Sleeping on my bed at night ⇨ Snacks from my plate ⇨ In my lap when I watch TV	• Staff don't let me drink what I want • Teddy leaving me during mealtimes • Staff not letting me buy things I want
Staff's perspective	• Favorite people doing activities with her, especially John Dandy • Keeping Julie from falling – reminders to use her walker • Level blood sugar - staff knowing signs of low and high blood sugar • Joanne is active in Julie's life • Planning before she goes shopping	• Julie is less steady on her feet and falling more than she used to • If you don't make a plan with her before shopping, she will want to buy more than she has money for – Julie may get very upset which can alter her blood sugar • Julie gives Teddy food off her plate.

The Learning Community For Person Centered Practices

Read Julie's Story with this slide up.

In this story you are the new house manager and one of the people that live in the house is Julie…

Julie is a young woman for whom life is going as well as it ever has. She has spent most of her life in an institution and moved to this group home about one year ago. She gets to shop and buy things that she wants. She has things that she likes. She gets her nails done. And most important, she has Teddy. At some time in her past something happened that caused her to not bond with people – she has been labeled as having an attachment disorder. For the first time in her life she has formed a real attachment. She is in love with Teddy. Teddy was the group home manager's dog, but the group home manager moved on and Teddy did not.

There are still challenges in Julie's life. She has severe diabetes and is referred to as a "brittle diabetic". This means that her blood sugar can change rapidly. Feeling upset, angry or even very happy will affect her blood sugar. She needs to have her blood sugar checked a number of times a day and gets frequent injections of insulin, she hates the finger pricks and needle sticks that go with this. Part of what staff does to help control her blood sugar is to weigh her food – this helps them know how much insulin she will need. But one of the things that make sense to Julie is to feed Teddy from her plate. This keeps staff from knowing how much insulin she should have. The staff response is to lock Teddy in another room. But there are other people in the house who

are distressed by Teddy's exile and let him out. Once he is back at Julie's side removing him upsets her which upsets her blood sugar.

You are the new house manager what would you do?

After reading, ask: **What do you think you would do about Teddy eating food off of her plate?**
Get consensus on a "Teddy plate"

The staff who support Julie are smart and caring – why do you think they had not come up with the Teddy plate idea? (you are looking for ideas such as tunnel vision on health and safety, a culture of control, etc.)

We get trapped in the current way we think about supporting people. The rest of the training will give you some tools to help people get "unstuck."

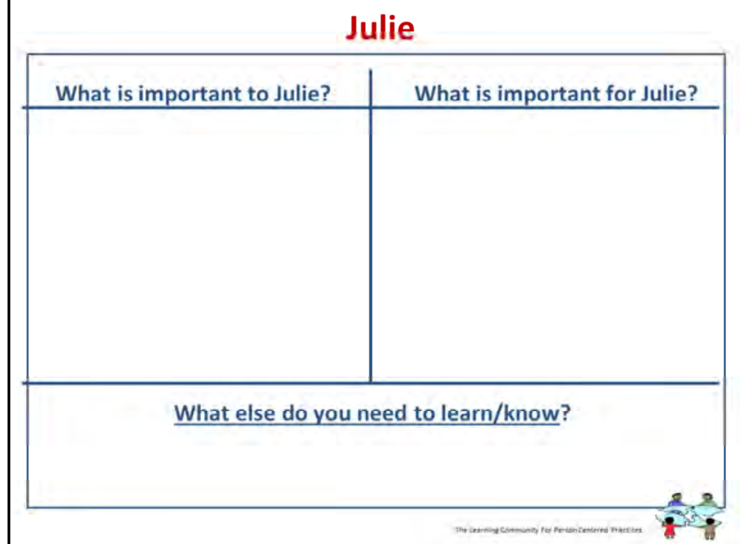
We often train staff to have tunnel vision about health and safety, and forget to look at what's important to people.

TIPS:

You can tell the stories or pass out the written copies. It works better if you tell the stories, but only if you are an OK or better story teller. Remember that if you tell the stories you have, to tell them as stories, don't just read them out loud.

Having highlighters on the tables is also helpful as some people will start highlighting 'important to' and 'important for' info as they read/hear it.

Next slide



OK, with the information you've been given, you're going to try to figure out what is *important to* Julie and *important for* her.

The "Teddy plate" answer reflects a balance between important to and important for.

We have another question at the bottom - "what else do we need to know?" This question should always be there because we never know everything and recognizing what we don't know is often critical in our efforts.

Ask the participants to work in groups (each table is a group) and have them fill this page based on Julie's story and the information in the works/doesn't work slide. Put Julie's "works/ doesn't work" slide back up.

The process should be consistent for the rest of the training – get people started and then wander around and help. When 80% of the people are done, ask for examples of what they wrote.

After participants share their answers, Click to show them the Julie answer slide. Give everyone a copy.

TIPS:

Be sure that you have your handouts are organized so that people don't get the "answers" before they do the work.

If someone comes up with a great answer that isn't on the sheet acknowledge it and move on.

On Julie's answer slide and a number of the other answer slides there could be more written, but there isn't room on the slide.

Next slide

Julie – Answer Slide

What is important to Julie?	What is important for Julie?

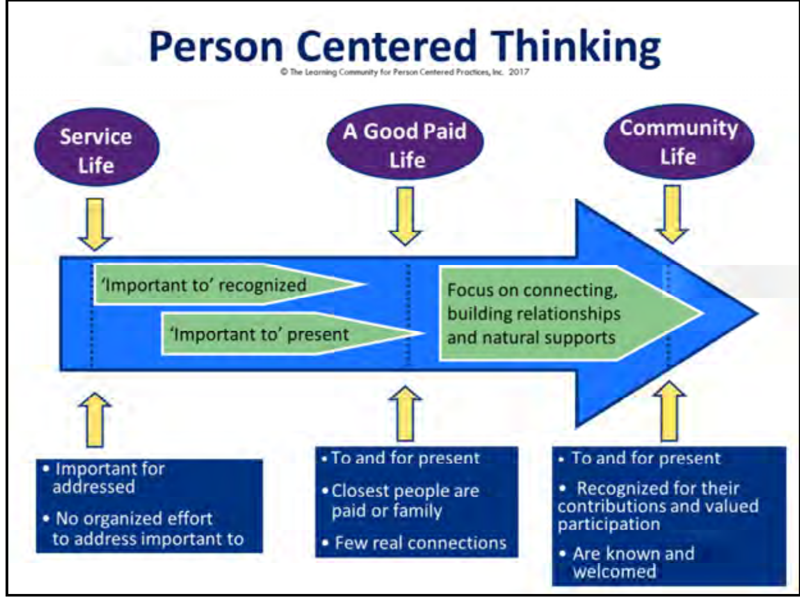
• Relationship with Teddy
• Having some control –
  • Over what happens with Teddy
  • What she buys/wears
  • Her things
• Shopping a lot
• Her sister & John Dandy in her life
• Staying busy at the day service
• Drinking as much as she wants
	• Keeping diabetes under control
	  • Monitoring blood sugar, giving insulin
	  • Weighing her food
	  • Controlling amount she drinks
	• Helping her stay calm
	• Supporting her relationships with Teddy
	• Keeping her from falling
	• Planning in advance/budgeting in advance for shopping

What else do you need to learn/know?

- How interested/involved is Julie in her diabetes management?
- What about "being bored" bothers her? How would she like to spend her day?
- Is John Dandy really important to her?

Here are the answers for Julie.

Next slide



Think about where the people who have disabilities often are.

The required minimum standard is "service life":

- **Issues of health and safety are adequately addressed**
- **Presence of what is "important to" depends on who supports you/how much they care**
  - **It is random and unpredictable.**

A good but Paid Life is not a bad place to be.

- **Most (about 80%) of what is important to you is present**
- **You are healthy and safe.**

But if we look at who is close to you:

- **Either family,**
- **Other people who use services,**
- **Or people who are paid.**
- **You go to places in the community where you are welcomed**
  - **You have some community presence.**
  - **Real community connections are lacking.**
- **What you have is fragile in that you are dependent on the ongoing commitment of the organization that supports you.**

Community Life is the goal. When you are here you may still have:

- **People who are paid in key roles,**
- **Those who watch out for you and plan with you are mostly unpaid**
- **You are not just present, but participating.**
- **Your gifts are recognized and there are opportunities for you to make a contribution.**

Community Life represents the intent of the CMS HCBS Rules.

Next slide

When you look across the lifespan and a typical trajectory for most people, there are general milestones and expectations as people age.

ASK: **What are examples of this?**

Possible examples:

- School – Participate in extracurricular activities
- Transition – Expectations to work or go to college
- Aging – Retire in our 60s

Those who have just a service life won't follow the same trajectory.

The more someone is involved in community life, the more likely they are to experience a full life.

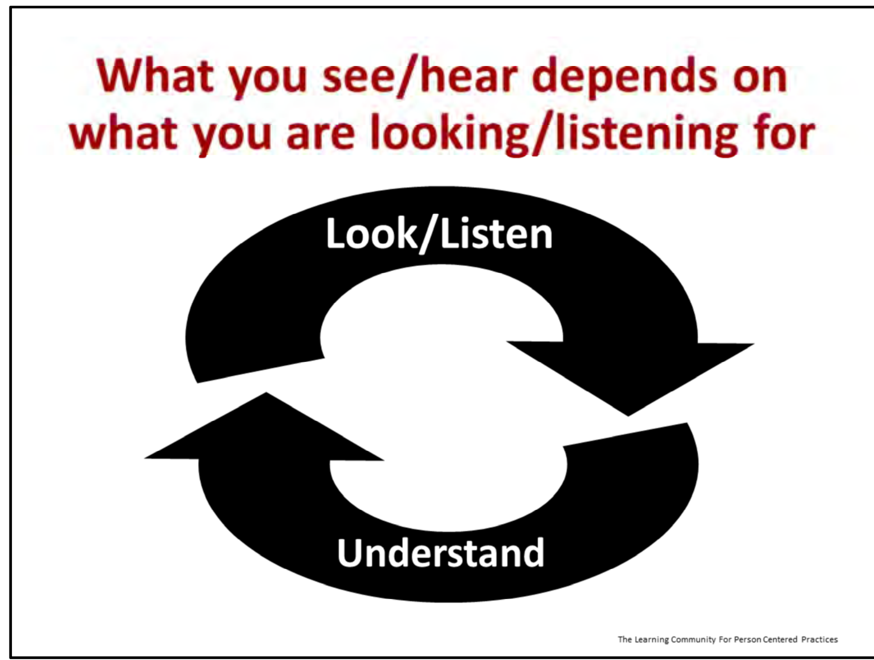
If doing intentional planning guided by the person's vision and goals, combined with supports to help achieve the goals and vision, the more likely their life would mirror the life trajectory we typically expect.

End of Important To/Important For section.

Next slide

In order to be successful when planning with members, you have to have meaningful conversations.

Next slide



What you see and/or hear depends on what you are looking and/or listening for. Person centered planning requires us to "look and listen" differently. It's all about listening to have better understanding and for that, one must let go of what you want to hear or are afraid to hear.

Next slide

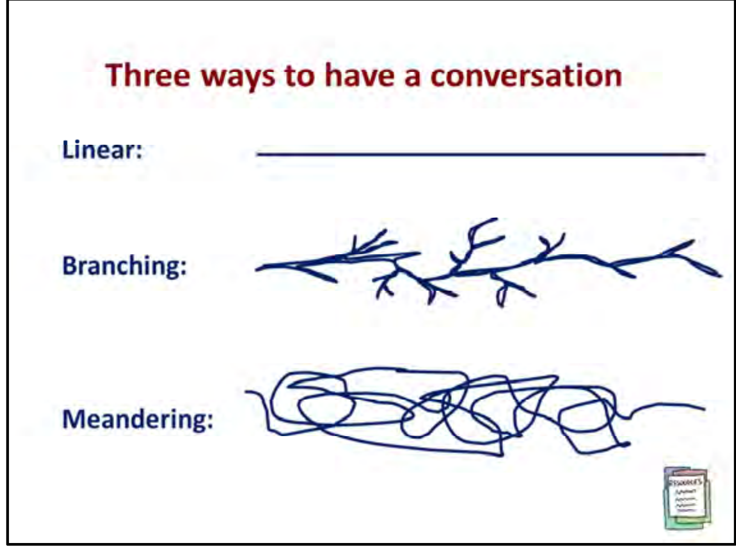
Here's a video that illustrates that concept.

https://www.youtube.com/watch?v=IGQmdoK_ZfY

Questions in video – if possible, pause video with each question to get responses from participants:
How many noticed the gorilla?
How many saw the player with the black shirt leave?
How many saw the color of the curtain change?

Have any of you seen this video before?

Next slide



There are three ways to have a conversation – linear, branching, meandering.

With the linear approach, you talk with the person simply about how they go about their day.

- **What is a typical morning like?**
- **Move through talking about the day in pieces and asking for good and bad versions of that part of the day**

The branching approach stars the same way, walking through time with the person. However, you look for opportunities for the person to tell you related stories about other parts of their life

Meandering is the most natural way to have a conversation, but it can also be difficult.

- **Instead of walking through time with someone, you start with an initial question and follow wherever it leads.**
- **Shape the conversation to hear stories about what's important to the person across all areas of life**
- **This requires skill to have a mental map of what you want to learn while also listening for the unexpected.**

In the resource section of your binder is an article by Michael Smull on conversation styles.

Next slide

Meaningful Conversations

Conversations ***- Not an interview or interrogation***

Engage

- Start with small talk
- Find common interests and experiences
  - Share something about yourself
- Ask permission for topics of discussion
- Collect your thoughts before you speak

Ensure that the member remains in charge as we learn

AHCCCS Person-Centered Service Plan Pgs. 2-3

Meaningful conversations are just that - *Conversations* - *Not an interview or interrogation.*

The first phase is engagement.

- **Sets the stage for process**
- **Start with small talk**
- **Explore common interests and experiences**
  - **Share something about yourself**
- **Ask permission for topics of discussion**
- **Think about what you want to say before you speak**

Ensure that the member remains in charge as we learn.

Next slide

Meaningful Conversations

Discovery

- Open ended questions - draw out what is "important to" member – Ask about:
  - Life experiences
  - Important people
  - How and where they spend their time
  - Would they like to try something else
- Remember past discussions - inquire
- Look around and observe objects/photos to spark conversation

AHCCCS Person-Centered Service Plan Pgs. 2-3

During the discovery phase, you try to get to know them better. This is where you ask more personal, open ended questions.

Show that you want to hear what they have to say.

- **Ask about their life and experience**
- **Favorite places to go**
- **What do you think would be the perfect job?**
  - **What do you like about that?**
- **Learn about their family**
  - **What do you like to do with your family?**
- **How many siblings do you have?**
- **Ask about where and how they spend their days**
  - **What do you do during the week?**
  - **How long have you been there?**
  - **What do you like about it?**
  - **Would you like to do something else?**

Remember past discussions and ask them about something they've told you before

- **How is your pet?**
- **Did you have fun on your vacation?**
- **How was the movie you said you were going to see?**

You can always look around and observe objects or photos to help start a conversation.

Next slide

Meaningful Conversations – Connecting on a Deeper Level

- Follow general questions with more specific questions
  - Tell me more about that…
  - What was it like…
- Acknowledge feelings and respond accordingly
- Discover their goals and dreams
  - "What do you think would be the perfect job?"
  - "What used to be your favorite thing to do?"

AHCCCS Person-Centered Service Plan Pgs. 2-3

To get to know them on a deeper level:

Follow general questions by asking for more detail

- **"Tell me more about that…" is always a good question**
- **What was that like for you?**

Acknowledge the feelings expressed and respond accordingly

Discover their goals and dreams with questions like

- **What do you think would be perfect job?**

For older members

- **What used to be your favorite thing to do?**

Next slide

Meaningful Conversations – Listen well

- Practice reflective listening
  - Repeat what they said - check for understanding
- Try to respect silence
- Be aware of body language - yours and theirs
- Be aware of behavior and non-verbal communication
  - Always look to member to confirm what other's report
- Validate their experience

Listen well by practicing active listening

- **Take the time to listen and try to understand their words**
- **Repeat back to them what they said and check for understanding**
- **Be patient and respect silence**
- **Be aware of behavior and body language, both yours and theirs**
  - **Stay open, relaxed and turned toward the person**
  - **Nod, smile and use other facial expressions**
  - **Maintain eye contact**
- **Approach conversation openly**
- **Listen to different viewpoints without reacting negatively – hear them out**
- **Validate their feelings and experience**

In your resource section of the binder you have a paper about Active Listening written by Carl Rogers and Richard Farson.

Next slide

Here's a case example of the interview process.

After video is finished:

Next slide

Conversation

- What types of conversations did you observe?
- How did the case manager show she was listening?
- In what ways did she connect on a deeper level?
- Do you think the member felt she was heard?

Ask the following questions – click for each to appear:
What types of conversations did you observe?

How did the case manager show she was listening?

In what ways did she connect on a deeper level?

Do you think the member felt she was heard?

Next slide

Important To/Important For

From what you observed in this interview:

- What do you think is Important To Vee?
- What do you think is Important For Vee?

Use flip chart paper to record answers. Draw a line down the middle and head columns with Important To and Important For.

Be sure to explore further if things that are "Important For" are identified as "Important To" and vice versa. Talk them through it.

Ask: **From watching this interview, do you get any ideas of what might be important for Vee?**
Write responses down in the Important To column.
Possible responses:

- Her grandson
- Spending time with family
- Cooking and sewing
- Getting to see her grandson
- Spending time with her granddaughter
- Teaching her granddaughter how to be a good woman
- Being in the loop (knowing why grandson is in jail)

Any ideas about what is Important For Vee?
Write responses down in the Important For column.
Possible responses:

- Being around people
- Having someone check-in or live with her
- Mental and emotional well-being
- Hygiene/personal care needs met

What else do we need to learn?
Take a few responses from the group.

Next slide

How to Use the Prompting Questions

- Use prompting questions as a jumping off point
- Follow up with more specific questions for deeper understanding
  - Tell me more about that…
  - What do you like about that…
- Don't ask prompting questions that:
  - Don't apply to the person
  - May have already been answered when discussing something else

There are many prompting questions on the new Person-centered service plan.

Use the prompting questions as a jumping off point to help you remember important topics to cover.

Follow up with more specific questions for deeper understanding

- **Tell me more about that…**
- **What do you like about that…**

Don't ask prompting questions that don't apply to the person.

You can reword them in ways to help the member understand.

Next slide

Documenting Conversations

- Be sure to document discussions from the meeting
- Each section has space for summary or notes of what was discussed
- Information obtained when asking about one section may give you what you need in another
- Documentation must be meaningful
  - Ensure next person touching the file will understand what is important

Any issue discussed that requires follow up must be documented in the Action Plan!

Be sure to document information obtained during the meeting.
Each section has space for a summary or notes of what was discussed.
Since you will be using a conversational format, you will likely hear information when asking about one section that may give you what you need in another.

Documentation must be meaningful:
Think about whether or not the next person touching the file will understand what is important.

Don't forget – any issue discussed that requires follow up must be documented in the Action Plan. It doesn't have to be related to a specific goal or outcome.

Next slide

Discovering Strengths & Preferences

Here are a few questions you will find on the AHCCCS Person-Centered Service Plan

- What are you good at?
- What do others like and admire about you?
- Who do you like providing support?
  - What about them makes them a good supporter/service provider?
- Are there activities you used to enjoy doing that you can no longer do?
- Do you have any beliefs or preferences that affect the care you receive?

AHCCCS Person-Centered Service Plan Pg. 3

Discovering strengths and preferences of the member is one of the most important tasks.

Ask: **How would you find this out?**

Take a few responses.

Click

Here are some questions on the new service plan to help you determine some of this:

- **What are you good at?**

- **What do others like and admire about you?**
  - **Asking team members this question is a great way to start out the meeting on a positive note.**
  - **Doesn't include things we only say about people with disabilities.**

- **Who do you like providing support?**
  - **What is it about them that makes them a good supporter?**

- **Are there activities you used to enjoy doing that you can no longer do?**
- **Do you have any beliefs or preferences that affect the care you receive?**

Remember, these are just a jumping off point.

Next slide

Preferences & Strengths

Be sure to include:
- How the person communicates
- Important routines and rituals
- Favorite things to do
- How they like to spend their time

These are not always revealed by asking questions
Team members may be able to shed light on these

Person-Centered Thinking Discovery Tools help to gain deeper understanding

AHCCCS Person-Centered Service Plan Pg. 3

Recording of preferences and strengths is extremely important for people who will be supporting the member.

Be sure to include:

- **How the person communicates**
  - **Do they speak or use assistive technology?**
  - **Do they use sign language?**

- **Important routines and rituals**
  - **What are the important features of their schedule?**

- **Favorite things to do**
- **How they like to spend their time**

You can't always find out these types of things by asking direct questions. You may get some of the answers from the team members who know the person best.

Person-Centered Thinking Discovery Tools are helpful to gain deeper understanding of a person's preferences and strengths.

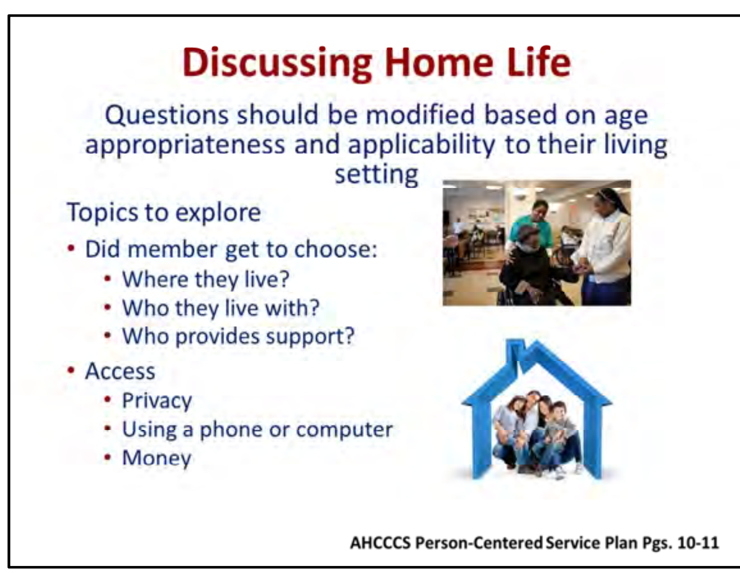
Next slide

The new HCBS rules require that settings must be integrated and support access to the greater community.

Be sure to document if:

- **The setting is the member's choice**
- **Community integration is supported**

Next slide



When discussing home life, all questions should be modified to reflect appropriateness for the member's age and living setting.

You want to ask questions about:

- **Did the member choose**
  - **Where they live**
  - **Who they live with**
  - **Those who provide support**

- **Do they have privacy?**
- **Do they have access to technology?**
- **Do they have access to their own money?**

Next slide

Explore whether or not the member is able to make day-to-day decisions about:

- **Eating**
- **Activities**
- **Ability to go places**
- **Who they spend time with**

Ask the member if they want to hear about or see other living settings.

Remember, any negative answers as a result of health and safety risk needs to be addressed when identifying risks.

Next slide

Discussing Home Life

Document:

- Current environment conditions
- Alternative settings discussed
  - Any information that helped inform choice
- If member expresses displeasure with current living situation or wants to look at other options
  - Be sure to note this:
    - In the Goals section of the plan
    - In the Action Plan

AHCCCS Person-Centered Service Plan Pgs. 10-11

Here are the things to be sure to document:

- **Current home conditions**
- **Were alternative settings discussed**

If the member is not happy with current living setting or wants to look at options, be sure to note this in goals and action plan.

Next slide

Talking about daily life. Once again, questions regarding how they spend their days should be modified to reflect appropriateness for the member's age and setting.

The goal is that the setting is the most integrated, least restrictive and affords full access to community living.

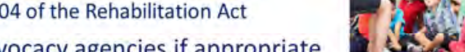
Document if setting is the member's choice and if community integration is supported and in alignment with the member's interests, preferences, abilities and health and safety.

Next slide

Discussing Daily Life

Children

- School is not their choice
- Work with parents to ensure they understand their child's rights in regards to
  - Individuals with Disabilities Education Act
  - Section 504 of the Rehabilitation Act



- Refer to advocacy agencies if appropriate
- Begin talking with children about:
  - What they want to be when they grow up
  - Their hopes and dreams for the future
  - Instilling the expectation of employment

AHCCCS Person-Centered Service Plan Pg. 12

Obviously children don't have a choice about whether they go to school, but work with parents to make sure they understand educational rights.

- **Individuals with Disabilities Education Act**
- **Section 504**

Inform families about advocacy organizations like Raising Special Kids, AZ Center for Disability Law, etc. if needed.

However, begin talking with children about:

- **What they want to be when they grow up**
- **What are their hopes and dreams**

These things are not always talked about with children with disabilities Start instilling the expectation that they will be employed when they are adults.

Next slide

For youth:
Continue talking with them about their hopes and dreams for the future

Help to identify the youth's strengths

- **What do they like to do?**
- **What are they good at?**

Talk about education and future opportunities
Promote "Employment First" when talking about transitioning to adulthood

Next slide

Discussing Daily Life

Youth (cont.)

- Help the youth and family to identify:
  - Things the youth does now that might transfer to job skills
  - Possible volunteer opportunities to gain more skills
  - Part-time work
  - Referral to Vocational Rehabilitation
    - Pre-Employment Services (as early as age 14)
    - Vocational training and services when job ready
  - Introduce family to AZ DB 101 to explore how working affects benefits

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Some ways to encourage Employment First is to help the youth and family discover

- **Are there things the youth has done or is doing that might transfer to job skills?**
- **Ways to gain more skills through volunteering**
- **Part-time work**

Referring to Vocational Rehabilitation as early as age 14 for

- **Pre-employment services to learn soft skills and**
- **Vocational training and services when ready for employment**

Talk with families about AZ DB 101 to learn about how working affects benefits.

Next slide

Here are some things to cover when working with adults.
If of working age – promote "Employment First" – People with disabilities can work too.

Talk about how they spend their day and
Did they choose:

- **What they do and where they go?**
- **The type of program they attend?**
- **The type of job they have?**

Are they able to spend time with the people they want to spend their time with?

Next slide

Discussing Daily Life

Adults & Elderly (cont.)

- Do they have concerns about how they spend the day?
- Would they like to do something different?
  - What do they want to change?
  - Would they like to:
    - Take classes
    - Obtain job skills
    - Get a job or volunteer
  - Explore all options with them

AHCCCS Person-Centered Service Plan Pg. 12

You can also ask the member:
Do they have concerns about their daily life?
Would they like to do something different?

If so, explore with them what some of the options might be, based on their strengths and preferences.

Next slide

Discussing Daily Life

Document:
- Current situation/conditions
- Alternative settings discussed
  - Any information that helped inform choice
- If member expresses displeasure with current situation or wants to look at other options
  - Be sure to note this:
    - In the Goals section of the plan
    - In the Action Plan

Any "negative" answers as a result of health and safety risk (unless for age appropriateness or appropriate to setting) needs to be addressed when identifying risks

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Be sure to document:

- **Their current situation**
- **Whether or not you discussed alternative settings and any information you provided to them to help them make a choice**

If the member isn't happy with the current state of affairs and/or wants to look at other options be sure to note this in the Goals section and the action plan.

Remember, any negative answers as a result of health and safety risk needs to be addressed when identifying risks.

Next slide

Medical Information

- Whenever possible, gather and update medical information prior to the planning meeting
  - Discuss updates only
- Talk about health status with member
  - How they feel emotionally and physically
  - Any changes
    - Medical status
    - Medication
      - Side effects
  - Guide member in taking more leadership in their health care

AHCCCS Person-Centered Service Plan Pgs. 4-9

Collection of medical information is always a big part of service planning. However, if possible, try to update medical info prior to the meeting by phone or email.

- **Have a discussion with the member about how they are feeling both emotionally and physically**
- **Are there changes in medical status or medication?**
- **Try to guide the member in taking more of a leadership role in their health care**

End of Conversations Section.

This is a good time for lunch break.
After break:

Next slide

Person-Centered Thinking

DISCOVERY TOOLS

The Person-Centered Thinking Discovery Tools can help you connect to a deeper understanding of the person.

Next slide

Person-Centered Thinking Discovery Tools

- Useful to obtain information not easily answered by direct questions
- Helps you discover Important TO and Important FOR which informs plans regarding:
  - Preferences and strengths
  - Important relationships
  - What works and doesn't work
  - Information to best support the member

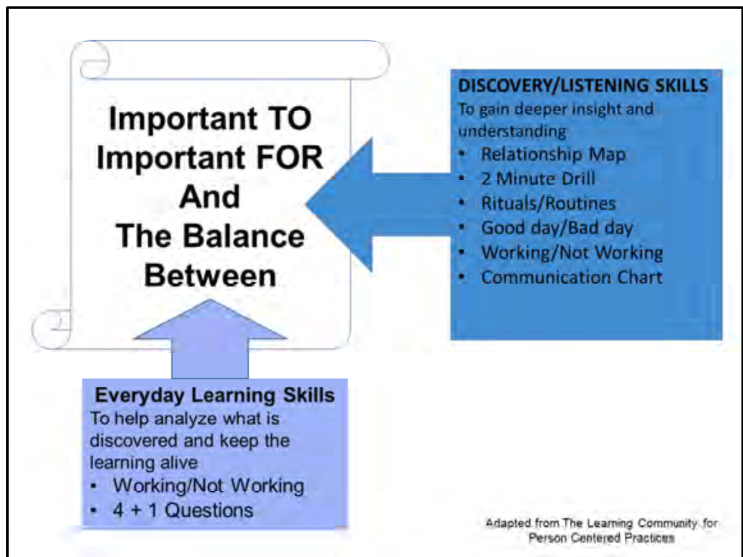
PCT Discovery tools are helpful to obtain information not easily obtained by asking direct questions.

Very helpful in discovering what's "Important To" and "Important For" the person.

These concepts are essential to inform plans in regards to the person's

- **Preferences and strengths**
- **Relationships that are important to them**
- **What works and doesn't work – what needs to change and what needs to remain the same**
- **Information to inform how best to support the member**

Next slide



These tools help you to identify Important To & Important For and the balance between the two.

The Discovery/ Listening Skills tools to gain deeper insight and understanding that we are going to talk about are:

- **Relationship Map**
- **Rituals & Routines**
- **Good Day/Bad Day**
- **Communication Chart**
- **Working/Not Working**

Later we will discuss tools to help analyze the information discovered and to continue to grow the plan.

Next slide

Types of Relationships

- Family
- Close relationships
- Paid services and supports
- Natural supports
  - Non-paid supports & community connections

Including these people on the planning team may be helpful to obtain needed information

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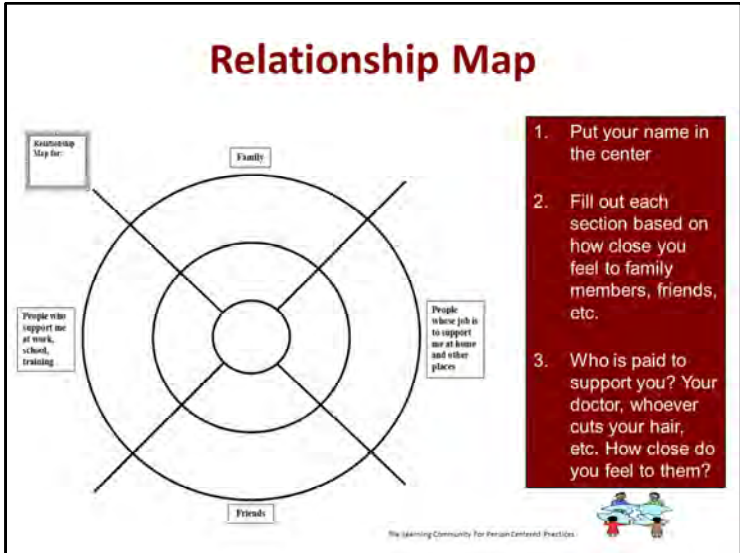
Finding out more about the people that are close to the member can help your planning in a variety of ways.

Some important relationships are:

- **Family of choice**
- **Close relationships**
- **People who are paid to provide services and supports**
- **People who provide natural supports**
  - **Non-paid supports & community connections**

Next slide



One of the most important PCT discovery tools is the Relationship Map.

Activity
We're going to have each of you fill out a relationship map for yourself.

Explain how to use the relationship map by reading the directions on the slide. If the group doesn't seem to understand, you can demonstrate by filling one out for one of the instructors.

Have everyone fill out their own relationship map.
Give a few minutes for people to fill them out.

Ask: **How was that for you?**
Pause for responses.

Once you have filled this out with the member, it should give you an idea of who they see as important to them.
Can also be used as the basis for other discussions.

Next slide

2 Minute Drill

Helps learn vital information on how to best support a person

Activity

- You have just been hired by a company that prides itself in supporting its employees
- They want to know what are the key things that you find helpful to be a productive employee
- You want to give them an overview, a summary in 2 minutes of what they need to know to support you successfully
- What would you say?

Choose who will go first.

You will have the opportunity to be in both roles.

Another helpful way to obtain information regarding support needs is the 2 minute drill. This is where the member and/or caregiver has 2 minutes to give an overview or summary of what someone needs to know to provide support to the member.

We're going to give you an opportunity to experience this.

READ SCENARIO ON SLIDE.

Find the activity sheet that says "2 Minute Drill for _____."

Everyone pick someone you don't know to be your partner.
Give some time for them to find someone. After they are paired up:
Click
Read slide
You will each have a chance to do a two-minute talk while the partner takes notes to determine the best way to provide supports for you to be successful. You will each have a turn.
Ask: **Any questions before we start?**

Time for 2 minutes.
Have recorder take notes about what the person wants them to know about what is important and how they can best be supported.
2 minutes

Time for another 2 minutes
Have recorder take notes about what the person wants them to know about what is important and how they can best be supported.
2 minutes

Ask: **Was this helpful? Does it give you a start to know what else you need to know, things to look out for?**

Next slide

Using the Info to Determine Important to/Important for

Guess: look at the information collected and guess what's important to the person

Ask: ask the person if your guess is correct; have a conversation for deeper understanding

Write: write down what you learn

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This is how to use the information you obtained to discover what is Important to/Important for the person.

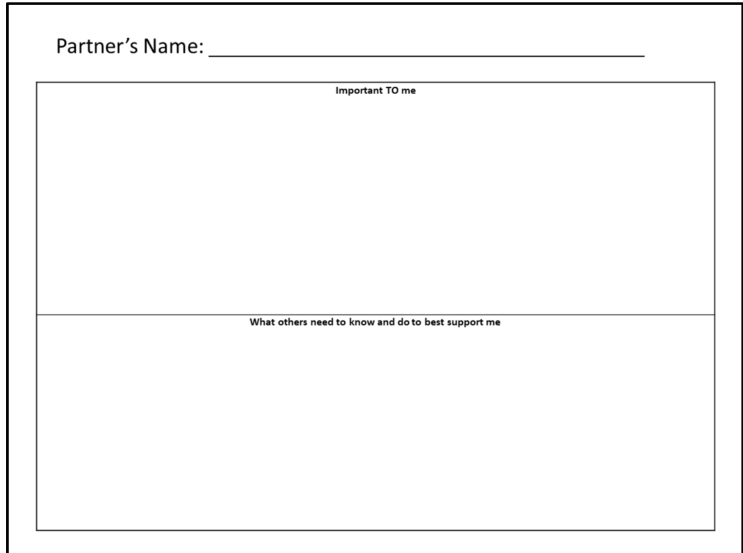
Review info on the slide.

Find the activity sheet that says "Partner's Name: ________" to record what is Important to/Important for your partner.
Click to next slide to show example of activity sheet.
Each person will complete this for their partner.
You will use this sheet to compile information about this person for all of the partner exercises which will result in an initial person-centered description for each of you.
Return to this slide.

You'll have 10 minutes for this activity. I will give you a heads up at 5 minutes to make sure you switch so each person has a turn.

When finished:

Next slide



After showing this, go back to previous slide.

When returning to this slide after activity:

Ask: **Would anyone like to share their experience?**
Allow a few people to share if they want.

The 2 minute drill is a quick way to learn a lot about a person.

Next slide

Routines and Rituals:

- Guide us through our days and bring consistency, comfort and control
- Are the "little things" that determine if we are happy
- Written up, they let others know how to support us in ways that keep us happy and safe

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Another important Discovery Tool is Routines and Rituals.

- **We all have routines and rituals that help guide us through our days that bring consistency and a sense of control to our lives.**
- **These are little things that contribute to our happiness.**
- **Documenting this information let's others know how to best support us.**

The question isn't whether or not people have important rituals or routines, the question is which ones need to be described.

The more significant the routine is to the person and the less control that person has over his/her life the more important it is to have it written in a way that assures that the person gets it.

Ask the following for a show of hands:

- **How many of you are morning people?**
- **How many of you crawl out of bed and don't like to talk until you have coffee?**
- **How would the non-morning people feel if they were awakened by cheerful morning people who want to talk?**
- **What if they insisted on waking you up one hour early because it was convenient for them?**
- **Who showers in the morning? At night?**

We all have set routines we go by.

Next slide

In a minute, we're going to have you all write out your morning ritual in detail, but first let's look at Amanda's morning ritual. You can find this in your workbook under the Stories tab.

Read Amanda's ritual to class.

Amanda's Morning Ritual

7:00 am   Alarm goes off, clock says 7:15 a.m. Music ONLY no buzzer hit snooze once or twice (depending on how late I went to sleep) get up at 7:09 or 7:18 a.m. If up late skip breakfast.

Stand in closet, with door shut so light won't wake husband and decide what I'm going to wear for the day.

7:15 am   Take clothes to bathroom, turn on water in shower-must be hot, remove pj's, get in shower, 1st wash body with MILD soap, then wash hair-mild shampoo, rinse, sometimes shave legs

7:25 am   Get out of shower, use 100% cotton towel that is not 'slick', dry off hair 1st work down to ankles. Feet dry on their own. Spray conditioner (Paul Mitchell) leave in and comb through

Wash face with Clinique-mild soap, no wash cloth, use clarifying lotion and

remove eye make-up with Clinique make-up remover

Put on deodorant and powder-antiperspirant (only if really hot). Put on underwear, then top. put on eye liner and mascara-No other make-up! (hurts face) Put mousse in hair.

7:45 am Go into kitchen fix breakfast: Bran cereal w/skim milk, banana, OJ. Eat breakfast in living room while watching the Today Show and the Weather Channel on the 8's sometimes

7:48 am Give cereal bowl to Oreo the cat

8:00 am Go back to bathroom, blow dry hair: Use big brush and spray gel to hold

8:17 am Brush teeth, put on slacks or skirt. Find shoes

8:23 am Quickly kiss husband good-bye and decide if coming home for lunch. Look for keys and purse, run out the door get in car, leave for work

Ask: **What are a just a few things you learned about Amanda from reading her ritual?**
Point out a few items from one of the sample morning rituals and note that you want similar detail. Amanda is a trainer who lives in Missouri. E.G. - the use of personal care products – some can be generic some can't. Is that true for those in the audience? One way to illustrate what you are looking for is to say –

Notice that Amanda gets partially dressed, then does a few other things, and only then finishes getting dressed. How many of you get dressed all at once? How many of you get dressed in phases – that is, you put some clothes on then go do something else and then put

on some additional clothes, etc?

This is the kind of detail that we are looking for.

Know your audience. This exercise has been used for more than a decade. If you are doing this with a group where a number of people have already done this exercise they will be cranky if they are made to do it again. Offer them the opportunity to describe another ritual in detail.

Feel free to substitute your own ritual here. Just remember that you want detail written, but you will lose your audience if you read it out loud. Providing your own personal examples sometimes help people connect with you as a trainer and assists them in feeling more comfortable in sharing their personal information. Again, emphasize the importance of detail – note that it is because of the detail that we know that it is important to Amanda to know what the weather is going to be.

Next slide

Morning Ritual – Part 1

- Write down your morning ritual –
- Include as much detail as you are comfortable with
- Start with how you wake up and end with leaving or when you feel the morning is over
- Tell us how long it takes – indicate what time it starts and what time it ends

Find the sheet in the activity section that says "_________'s Morning Routine," and fill in your name. Use this page to write your morning ritual in detail. However, be aware that someone else will be reading it; so don't record something you don't want others to know.

We don't need to know about anything that "leaves your body," so please omit that part.

The ritual should start when you get out of bed and end when you are ready for the day, and/or leave for work.

Tell us how long things take, what time it starts and what time it ends.
Give 10 minutes.

Next slide

Morning Ritual – Part 2

- Work with your previous partner, look at each others morning ritual and learn what is important to your partner
- Take the same sheet of paper that has "Partner's Name" at the top
- Read your partner's routine and then –

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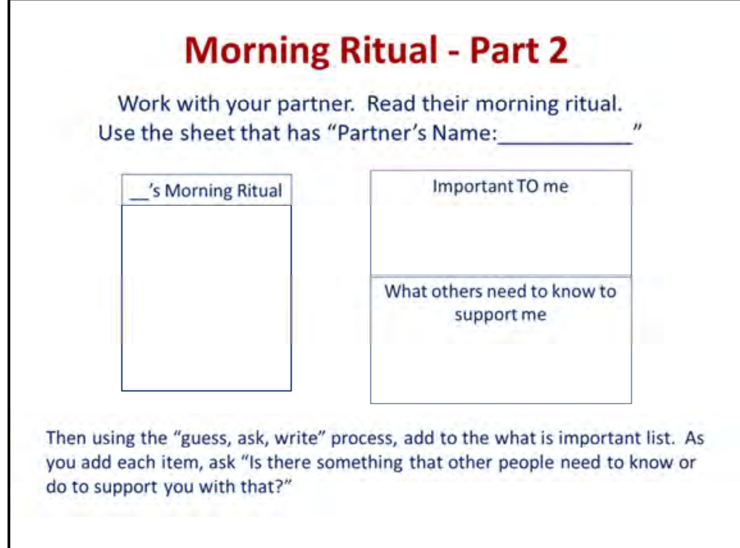
Now get together with your same partner and switch your routines.

Work together to review each other's morning ritual and learn what's important to your partner.

Take the sheet of paper that has "Partner's Name" at the top.

Read your partner's routine, then –

Next slide



You're going to use your partner's description of their Morning Ritual to learn "What's Important to" and "How to Support" them. You'll work with your same partner and go through the guess, ask and write process like you did the last time.

Click on the next slide.

Come back to this slide.

Give 10 minutes

Next slide

Using the Info to Determine Important to/Important for

Guess: look at the information collected and guess what's important to the person

Ask: ask the person if your guess is correct; have a conversation for deeper understanding

Write: write down what you learn

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Review info on the slide.
Click back to previous slide
Give them about 10 minutes to do this. Be sure they switch after 5 minutes.

When finished:

Would anyone like to share their experience?
Allow people to share what happened for them.

For a minute, let's talk about getting a new morning ritual.
Look at your morning ritual and take out the first 2 things, after getting out of bed. This is now your new morning routine.

Think about how this feels for you?
How do you think it would affect your day? Your behavior?

Now think about how this relates to the people we support.

Next slide

Other Rituals

- Transitions
- Comfort
- Birthday
- Cultural/Holiday
- Not Feeling Well
- Spiritual
- Vacation
- Celebrations
- Going to bed
- Grief/Loss

What other routines or rituals would be good to know in order to best support someone?

https://tlcpcp.com/docs/positive-rituals-and-quality-of-life

AHCCCS Person-Centered Service Plan Pgs. 3, 10-12

Here are some other rituals that might provide important information.

What other routines or rituals would be helpful to know and understand in order to best support someone?

Refer to the link on the slide – Positive Rituals
This information for all of us, but even more important for members with multiple caregivers.

This may be a good time for a break.
When back –

Next slide

Another tool to help gain deeper understanding about what's important to and important for is learning more about what makes a good day or a bad day for the member.

Next slide

Good Day / Bad Day

- It's helpful to look at specific situations or settings that contribute to one's day.
- You may need to start with what a typical day looks like to talk about what can make it better or worse.
- Knowing and respecting one's routines could be the difference between having a good day or a very bad one.

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Review slide and emphasize:
Knowing and respecting one's routines and rituals could be the difference between having a good day or a very bad one.

Give an example
Possible story:
Michael Smull tells a story about a man, we'll call him Jack, who absolutely had to have his coffee as soon as he woke up. Anyone who knew him, knew not to talk to him until he at least had one cup of coffee. He lived in a group home. One morning he got out of bed and walked in the kitchen. There was a new staff member he'd never met. He said to the woman, "Coffee." The staff member said, in a singsong voice, "Is that how you ask?" Jack said again, "Coffee." The staff said, "What's the magic word?" Jack again said "Coffee." The staff said, "Not until you say please!"
Jack went off! He started yelling and throwing things and it took a long time to get him to calm down. That was the beginning of a terrible day for him.

Now we're going to look at what makes up a good day or bad day for you at work.

Next slide

A Really Good Day at Work

- What happened that contributed to your good day?
- What do you look forward to?
- Who do you look forward to seeing?
- What happens that gives you energy to deal with difficult situations?
- What motivates and interests you at work OR on a work day?

A Challenging Day at Work

- What threw your day off?
- What made the day bad for you?
- What made you frustrated? Bored?
- What took the fun out of it?
- Be sure to include those daily frustrations

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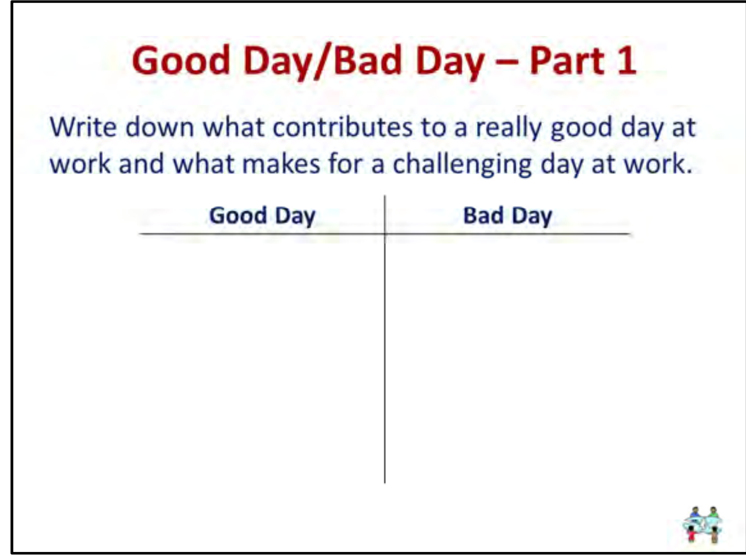
For example, if looking at work, some things to consider might include:
Review slide

This is what you are going to do for yourselves in our next activity.

Next slide



Writing down a "Good work day/Bad work day"

Everyone take out the sheet in your activity section that looks like this.
Give them a second or two to find it.

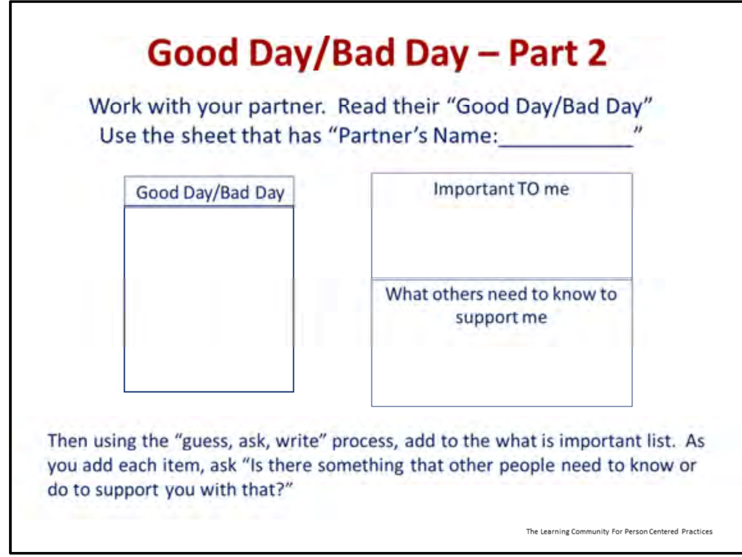
Think about what a good day and a bad day at work is like for you.
What kind of things contribute to a good day at work? Write those down on the left.
Now think about what kind of things contribute to a bad day at work? Write those down on the right side of the paper.

Explain rules (no fantasies, a composite of all the moments together)

Give about 2-5 minutes or so for them to write.

As with the morning ritual exercise, some people find detail easy and some find it difficult. If you are confronted with someone who says "I do not have bad days" ask for bad moments.

Next slide



Now let's look at how to use the Good day/bad day discovery tool.

You're going to use your partner's description of their Good Day/Bad Day to learn "What's Important to" and "How to Support" them. You'll work with your same partner and use the same activity sheet to go through the guess, ask and write process like you did the last time.
Click on the next slide.

Come back to this slide.

Give 10 minutes, make sure they switch after 5 minutes.
When finished:

Next slide

Using the Info to Determine Important to/Important for

Guess: look at the information collected and guess what's important to the person

Ask: ask the person if your guess is correct; have a conversation for deeper understanding

Write: write down what you learn

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Review info on the slide.

Click back to previous slide

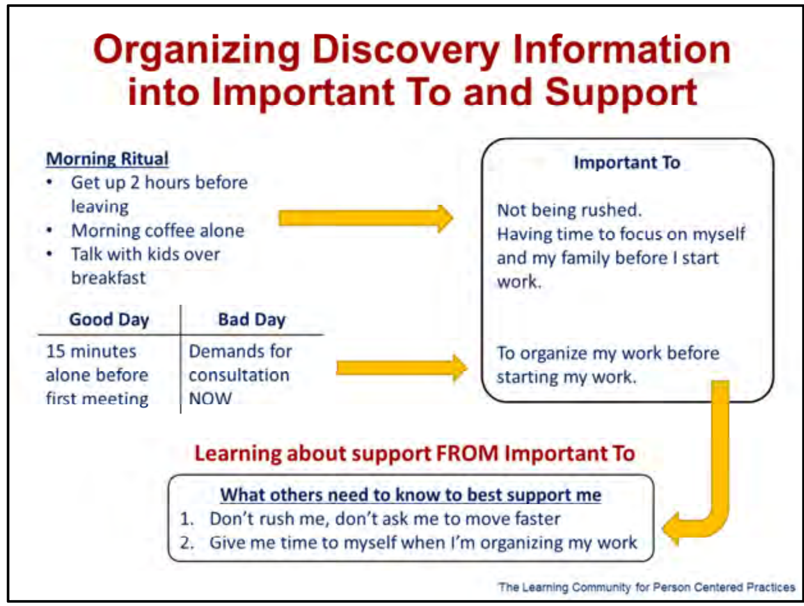
When returning to this slide after activity:

Would anyone like to share their experience?

Do you know what makes a good or bad day for the people you support?

What did you learn from this exercise?
How does this apply to your work?

Next slide



This diagram shows how to process the information you receive from learning the morning ritual and good day/bad day to determine what is important to the person and what others need to know to support.

Recap example on slide.

Next slide

Working/
Not Working

Another Discovery Tool is Working/Not Working.

Next slide

	What works/makes sense	What doesn't work/make sense
Julie's perspective	• Shopping for favorite things • Having lots of jewelry and no one getting into them without my ok • Having my sister Joanne in my life • Lots of blue, red and black clothes • Polished nails, many colors & layers • Living with Teddy, the Yorkshire ⇨ Sleeping on my bed at night ⇨ Snacks from my plate ⇨ In my lap when I watch TV	• Staff don't let me drink what I want • Teddy leaving me during mealtimes • Having no work to do at WAC, Inc. • Staff not letting me buy things I want
Staff's perspective	• Favorite people doing activities with her, especially John Dandy • Keeping Julie from falling – reminders to use her walker • Level blood sugar - staff knowing signs of low and high blood sugar • Joanne is active in Julie's life • Planning before she goes shopping	• Julie is less steady on her feet and falling more than she used to • If you don't make a plan with her before shopping, she will want to buy more than she has money for – Julie may get very upset which can alter her blood sugar • Julie gives Teddy food off her plate.

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Remember Julie's story? We're going to visit it again to talk about our next discovery tool – Working/Not Working.

Do not tell the story over, just point out –

This gives a picture or snapshot of someone's life at a moment in time.
It separates perspectives so that you can see what Julie thinks as opposed to what staff think.
While this slide only has 2 perspectives there could be more – there could be a separate set for Julie's sister.

Don't linger here – you are reminding them that they have seen it before and letting them know that it is what they will be working on next.

Next slide

Working/Not Working

Reflects current reality
- Everyone's perspectives should be reflected
  - Completed in partnership
- What is working now, not what would or could work
- Focus on a specific issue or area of life

Peel the onion
- Always ask the question behind the question
- Dig deeper to find more meaningful information

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Working/Not Working reflects what's currently happening.
This should be completed with the team and with everyone's viewpoint.

Remember to always ask the question behind the question to dig deeper.

Next slide

Use to organize perspectives about a specific issue or to get a snapshot description of NOW

What's Working	What's Not Working/ Could Improve
What does the person say is working?	What does the person say is not working or could be better?
What does the family say is working?	What does the family say is not working or could be better?
What does the staff person/teacher/therapist (etc.) say is working?	What do they say is not working or could be better?

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Working/Not Working is a snapshot in time that reflects what's happening now.
You could use it to focus on a specific issue or area of life.
It captures what's happening from the perspective of the person, their family or health care decision maker, and the professionals working with them.

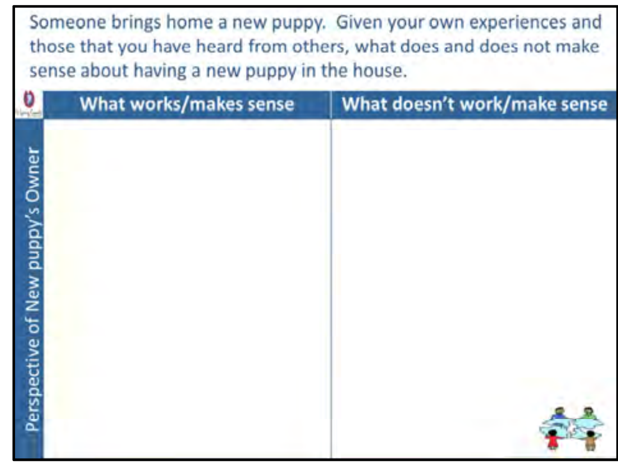
After this is completed, it can be used to develop goals and objectives that help people move toward the lives that they want.

This tool can be especially helpful with identifying goals and action planning.
The left hand column helps with identifying those things that you wish to maintain or enhance.
The right hand column shows things that need to change.

Next slide

Who doesn't love a puppy????

Next slide



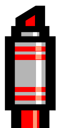
This activity can be done in small groups or a large group depending on the number of participants, the layout or size of training room, and/or the amount of time you have. See instructions for both below the intro to the activity. Regardless of the group size for the activity, the trainer will need to prepare flip chart paper for recording. Put a line down the middle and title the left with "What works/makes sense" and the right with "What doesn't work/make sense."

We're going use this tool for an activity to help you learn about how this works. Find this sheet in your activity section of your booklet.

Read the scenario on the top. Be sure to stress this is about what works/doesn't work right now in their lives, not what could work or if contingent upon something else and/or a specific situation.

Use this tool to write down what works and makes sense about getting a new puppy, and what doesn't work or make sense.

Small Groups:
Ask for 1 or 2 examples for each side and then have people work in their groups. Keep it light-hearted and keep people moving. Watch out for groups that are sharing stories without writing anything down. They should be able to generate a decent list in 5 minutes.*



Ask each group to share 1 item on each list. Write the responses on the flip chart paper. After you have asked each group to share, ask how many people would like a new puppy and how many people are saying

something on the order of “Hell will freeze over”? Point out that there seemed to be a lot of agreement about what item(s).

Large group:
Ask participants to give examples for each side, and record on flip chart paper. Write the responses on the flip chart paper. After you have recorded a good number of responses, have the class vote for who agrees for each one and record the number. Point out where there seems to be a lot of agreement on the items.

As you can see, no situation is all good or all bad. What determines what people do is the “weight” that people give to the items. For one person, the “weight” of some of the items in the ‘makes sense’ column, creates a balance that tips toward having a puppy. For others, the items in the ‘doesn’t make sense’ column cause them to decide that having a new puppy is not worth it.

Would your lists look different if you asked your kids to do this activity? What about your spouse or partner?

Next slide

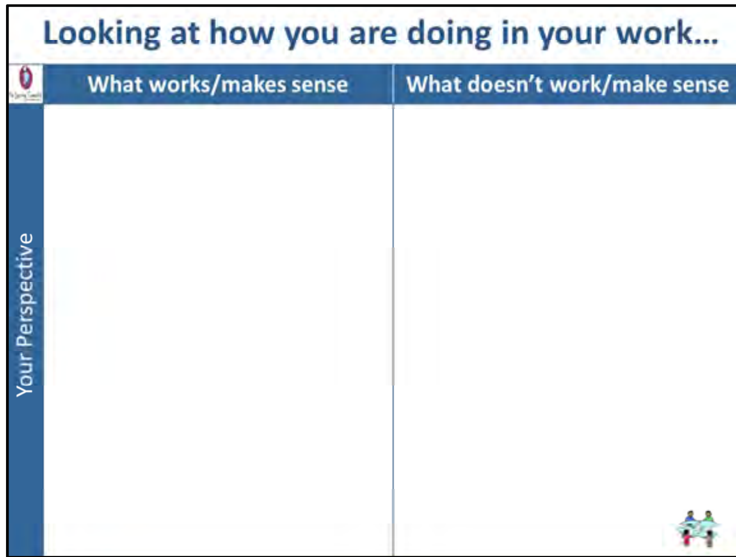
Looking at how you are doing in your work…

	What works/makes sense	What doesn't work/make sense
Perspective of Person Supported		
Your perspective		
Supervisor's perspective		

You can see how this could be useful in other situations.

Most of these tools have multiple applications, and this is an example. This could be a way to do an employee evaluation that would take into account more than just what the supervisor feels. If you were to add another row that was labeled "co-workers perceptions" you would have what is referred to as a 360 degree evaluation.

Next slide



Use this sheet from your booklet for you to examine how things are going for you at your job.

Use this tool to write down what works and makes sense vs what doesn't work/make sense for you at work.
Give the class about 5 minutes to do this independently.

What are some ways you might use this tool for yourself?
Possible examples:
- To get a clearer picture of how things are going for you at work
- Determining what changes you might be able to make to make things better
- Deciding whether to look for a new job
- Use for negotiating with your boss

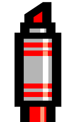
When reviewing what you've written, does it reveal things that are important to you?

Next slide

Words & Actions Matter

What are some of the words/terminology we use in the service community?

Our words and actions matter.
Ask: **WHAT TERMS ARE COMMONLY USED IN THE SERVICE COMMUNITY? Don't worry about being politically correct.**

 Write responses on a flip chart paper

Ask: **What do you notice?**
Take a few responses

Ask: **What stands out?**
Take a few responses

Do we use this language in our own everyday lives?
I'm going to read you a story called "The Importance of Language!"

Read the "The Importance of Language!"
While talking about "respect" during a self-assessment workshop, there was a lengthy discussion about the importance of language. Cheryl Rennick, one of the staff members who was participating from Community Living York South, realized there really were two languages – one for people who receive support, and one for people who don't. She went home and wrote the following story about her life using language that is typically used for people who receive support. There really are two languages and we need to stop it!

This morning I got up early so that I could complete my hygiene routine before everyone else was up.

At breakfast, I asked my husband, 'What activity would you like to participate in this weekend? Shall we stay home and do our relaxation program or would you prefer to go on an outing?"

"An outing?" "Yes" I said. "You know, go out into the community somewhere."

"I wouldn't mind inviting the Martins over to play some euchre." he suggested.

"The Martins!" I exclaimed. "I don't think so. They're much too low functioning for us. How about inviting the individuals from Willow Lane?"

"Sure." he said. "Sounds like fun to me."

Suddenly something occurred to me. "We can't invite the Willow Lane Gang! Remember the last time they were here they drank too much and then suddenly went into behaviors!"

"Behaviors?" he asked.

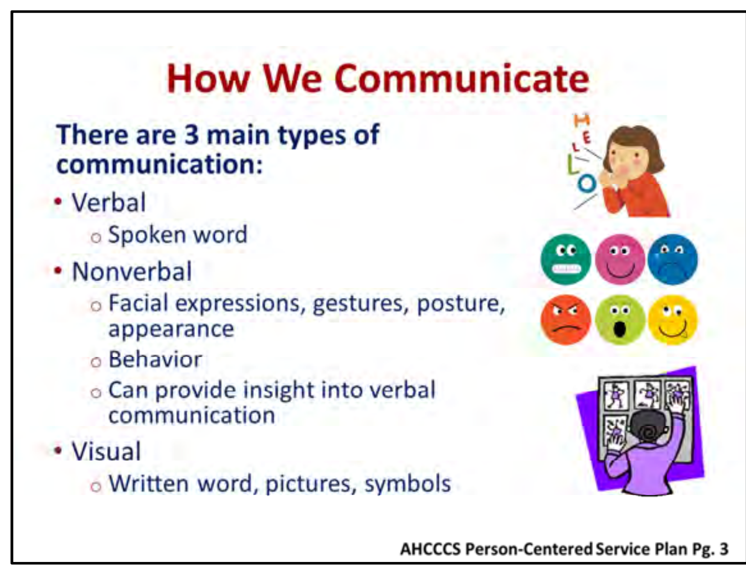
"Yes! Remember when he trumped her ace and then she began to verbally aggress against him and we had to de-escalate the situation? After they went home I needed to be PRNed!"

"Well then," said my husband, "Why don't we just go out to a restaurant?"

"Great idea! Should we make it a one on one activity or would you prefer to socialize with a few of our peers?"

Ask: **Any thoughts?**

Next slide



There are three main types of communication:

Verbal

Nonverbal

- **Includes expressions, gestures, behavior**
- **Can provide insight into what is said**

Visual

- **Writing, pictures, symbols**

Next slide

Total communication is communicating in any way you can:

- **Talking**
- **Signing**
- **With facial expressions and gestures**
- **Pointing to things to make sure someone understands**
- **We express ourselves through art as well**

Next slide

Total Communication
Communicating Any Way You Can

Through communication we:
- Build relationships
- Let others know how we feel and what we think

Ability to communicate
- Knowing you're being listened to

People who don't use speech still communicate
- You have to be more creative

Total Communication = Key to Inclusion

AHCCCS Person-Centered Service Plan Pg. 3

Communication is how we build relationships and express our thoughts and feelings.

When communicating, in any way, it's important to feel you're being listened to.

When people don't communicate with words, you just have to be more creative because total communication is the key to inclusion.

Refer to "Total Communication Minibook" in resources section.

Next slide

How We Communicate

Words and behavior don't always match

Some people don't use words to communicate – what are they telling us?

When we listen:

- Communication becomes more complex
- People become more interested in communicating in other ways
- A few people who didn't use words begin to do so

AHCCCS Person-Centered Service Plan Pg. 3

Words and behavior don't always match.

Some people don't use words to communicate – so how do we know what they are telling us?

When we really listen, people become more interested in communicating in other ways.

Next slide

Communication Chart

- Provides an at-a-glance view of key information about how someone communicates
- Especially useful in supporting people who don't communicate well with words
- Supports discovery and informs action

How do you get this information?

This information is ideally provided by the people who know the member best

AHCCCS Person-Centered Service Plan Pg. 3, 10-12

The next discovery tool is the Communication Chart.

It provides an at-a-glance view of important information about how a person communicates nonverbally.

This is useful for everyone, but is especially helpful when supporting people who don't communicate with words.

It supports discovery and informs action.

Who will provide this information?
Possible responses:

- Member
- Family
- Staff
- Friends

Be sure to say "the member" if nobody says it.

Click
Read sentence.
This is why having a good planning team is so important!

Next slide

We have four columns:

- **What is happening**
- **I do this**
- **It usually means**
- **And I want you to**

Point to column 2: **We usually start with column 2 describing the behavior we are seeing**

Point to column 1: **In the "What is happening" column is where we document what is happening when the behavior or action occurs. This is also known as the "trigger."**
You may find that you see a behavior in multiple settings or situations, and the meaning could be different for each

Point to column 3: **After observation and sometimes some detective work, we document what we think this action, in the setting, means – what the person is trying to tell us.**

Point to column 4: **Here is where you record what other people should do or not do in response.**

Next slide

Rhonda's Communication Plan

What is Happening	Rhonda does	We Think It Means	And We Should
You are pushing Rhonda	Locks her chair	I don't want to go there	Figure out with Rhonda where she wants to go
Rhonda is at the front door	Kicks the door	I want to go out	Help her outside (unless there is too much pollen, about to rain, etc.
Rhonda has stopped eating	Catches your eye, pulls down napkin	I'm done eating	Take leftovers away now
You didn't remove her food	Rhonda sweeps the food off her tray	I told you I was finished and you didn't listen	Clean up and do better next time

The Learning Community For Person Centered Practices

Here is a Communication Chart for Rhonda.

Go through and read the Communication chart first.

Then read Rhonda's story:
Rhonda is someone who doesn't use words to communicate, but as you can see she is someone who is quite expressive and a good teacher! Let me tell you a little more about her…

Rhonda lives in a group home and gets to/from her day program by her residential staff. Every day on the way home from her day program the van passes one block that always causes Rhonda to scream. The staff finds this disconcerting, both for themselves and Rhonda and so have learned a different route to get home so Rhonda doesn't scream.

Well, a new staff started at the home and didn't get the memo of the right way to go home. So, of course they went the quickest way, went on that particular block and of course, Rhonda began screaming. Well this staff was pretty observant and noticed on that bock there was an ice cream parlor. They stopped at the ice cream shop and Rhonda screamed until she got vanilla ice cream.

The next time they were on that block, Rhonda screamed until she got chocolate ice cream.

The next time, she screamed until she got a hot fudge sundae! Once we know what someone is telling us, they tend to communicate with us even more!!

This is not to say that you stop and get ice cream every time you are on that block. What it does is open up communication and understanding so you can compromise – "I know you want ice cream, but we had some yesterday and we need to wait until tomorrow/next week until we get some again."

Imagine what life would have been like (especially if you are an ice cream lover like Rhonda) if you avoided that block because people misinterpreted what you were trying to tell them.

Ask:
Can you see how this information could be helpful?
It's especially important when the member has multiple caregivers. It always helps for caregivers to share what they've learned or know about the person.

We have a few examples in the workbook. This isn't only for people who don't communicate with words.

You could take a communication chart home and give it to your friends or family and see if they have noticed any telling behaviors about you!

Next slide

Keep Culture In Mind

Culture is evidenced in comments like:

- That's not how we do things
- That is not right
- Nice people don't do that
- Women/men don't do that
- You will embarrass the family
- That is against my (our) religion

AHCCCS Person-Centered Service Plan Pg. 3

Always keep culture in mind when communicating.

Culture may be a factor if you are hearing statements like these:
Review statements on slide.

Next slide

Keep Culture In Mind

Those providing support should:
- Be aware of their own cultural assumptions
- Be prepared to express point of view in a transparent way

May need to:
- Consider other's cultural values and ask questions
- Plan how to explain cultural issues
- Be prepared to discuss more than once

AHCCCS Person-Centered Service Plan Pg. 3

When communicating, it's important to:

- **Be aware of your own cultural assumptions**
- **Be prepared to express your point of view differently**
- **You may need to ask questions for clarification**
- **Think about how to explain cultural differences**
- **And be prepared to discuss things more than once**

Give an example if you have one.
One possible example:
A man lived in a group home setting. The person's father told the staff member that he would be picking up his son to go to church on Sunday so to make sure to shave him. The staff member was from India, and she asked the father "Are you sure?" The father said yes, please.
When the father came to pick up his son he found that the staff had shaved off all of the hair on his body except the hair on his head! Can you imagine what that experience must have been like for the person being shaved??

Next slide

Your Opinion Please:

1) When I invite someone over, I prefer that they:
   a) Arrive a little early
   b) Arrive on time
   c) Arrive a little late
2) When someone I don't know well visits my home, I am:
   a) More aware of how I look and act
   b) More aware of how they look and act
   c) Aware equally of how I and they look and act
3) When anyone comes into my home:
   a) I prefer them to remove their shoes
   b) I prefer them to keep their shoes on
4) When I have company:
   a) I am not comfortable unless my home is perfectly clean
   b) I am OK with my home in whatever the state
5) When I have guests:
   a) I always offer them food and/or drink
   b) I do not offer them food and/or drink
6) When guests eat at my home:
   a) I eat first
   b) My guests eat first
7) When I offer food/drink to my guests:
   a) I am offended if they refuse to accept it
   b) I don't mind if they refuse to accept it
8) When guests dine with me in my home:
   a) I expect them to stay for a while after the meal
   b) I expect them to leave as soon as the meal is eaten

Lets do a little poll to see how we might reflect culture in every day life.
Raise hands to respond to questions (may not have to do all)

Ask:
Do you see how all of us have different opinions on things?
Are your responses similar to what your parent would say?

Next slide

In summary, the Discovery Tools help you discover how the person wants to live – what kind of life they really want.

Handout – Listen Ask Flow Chart

Now that we're done using the discovery tools on ourselves, give your partner back the information they shared and the page you used to fill out their Important To/Important For. This is the start of your own Person Centered Description.

End of Discovery Tools Section.
End of Day 1.

Next slide

Beginning of Day 2

Today we want to talk about how all of this fits into developing a Person-Centered Service Plan. We won't be telling you how to complete the new form, but more about how to obtain the information to make it person-centered.

Next slide

Definitions

- **Member-driven** (versus member-centered) = plan is yours to do/not to be done to you
- **Meaningful/informed choice** = knowing and understanding all the options
- **Natural supports** = non-paid supports and community connections
- **Support Team** = family, friends, providers & case managers/support coordinators

Here are some important definitions regarding Person-Centered Service Planning:

- **Member-driven (versus member-centered)**

  This is the member's plan and they are an active part of the process
- **Meaningful/informed choice means we are helping the member obtain all the information they need about options in order to make the best choice for them.**
- **Natural supports are non-paid supports and community connections.**
- **The support team can consist of anyone the member identifies.**

Remember the member is always present.

Next slide

PCSP is Member-Driven

- With information and support
- With time to learn the member's wishes and life goals
- With involvement by people chosen by the member (e.g. family, friends, support people)

The member is in the driver's seat in the planning process.

Information and support needs to be given and time and effort is needed to learn about what the member wants.

The member chooses the people they want to be involved in the planning process.

Next slide

The new AHCCCS Person-Centered Service Plan is designed to celebrate accomplishments.

The review and revision cycle has not changed:

- **Annually for acute care members**
- **Every 90 days if receiving HCBS**
- **Every 180 days if in a nursing facility or DDD Group Home**

But a review can also be done at any time when circumstances or needs change and/or at the request of the member.

Next slide

Person-Centered Service Plans are built on the members strengths, preferences and support needs.

They include opportunities for meaningful activities the member finds desirable such as employment, community activities and volunteering.

Next slide

Person-Centered Service Plans

Promote
- Independence and
- Community inclusion

Create services and supports that meet the member's needs and life goals:
- Paid services and supports
- Natural supports in community, family

Person-Centered Service Plans promote independence and community inclusion, and create supports that meet the members needs and life goals.

This might be done with paid services and supports and/or natural/non-paid supports.

Next slide

Person-Centered Service Planning is NOT:

- an attempt to “fix” the person
- a “behavior plan”
- a standardized process
- dwelling on reputations or labels

STOP

It is sometimes easier to describe by saying what it is NOT.

- **PCSP is not an attempt to “fix” the person – people are not broken**
- **These are not behavior plans**
- **Each plan is individualized**
- **PCSP meetings accentuate the positive – don’t dwell on reputations or labels**

Next slide

Person-Centered Service Planning IS…

☑ a way to organize information & in plain language
☑ toward a desired future
☑ giving respect for choices
☑ promotes valued roles
☑ positive, respectful & sensitive
☑ capacity focused
☑ an accurate picture
☑ action-oriented (plan-do-evaluate)

This is what person-centered service planning is:

- **A way to organize information & in plain language**
- **Focuses on a desired future**
- **Giving respect for choices**
- **Promotes valued roles**
- **Positive, respectful & sensitive**
- **Focused on a person's capacity**
- **Gives an accurate picture**
- **Action-oriented (plan-do-evaluate)**

Next slide

Person-centered service planning results in a service plan that identifies:

- **Strengths, preferences & needs**
- **Goals and desired outcomes of the member**
- **Services/supports to help the member achieve desired outcomes**

The plan also identifies risk factors and plans to minimize them in a way that does not restrict someone's rights.

Next slide

This pyramid is another way of thinking about it, and it is similar to Maslow's Hierarchy of Needs.
Review the contents of the pyramid from bottom to top.

This is not a disability/chronic health condition issue. This is true for all people. A full life has components of all of these levels.

We all need and receive support.
We all contribute, not just through our jobs, but by how we spend time and through relationships.
We all want to have control over our lives – to strive to achieve our dreams.

We've already talked in depth about important to and important for, and the pyramid reflects those aspects as well.

Have any of you ever had a time in your life when you didn't feel safe?
The focus of your "dream" then was to be safe.

Had a sudden health crisis - and getting healthy consumed you?

These are times when what is "important for" us becomes the dominant

focus.

How many of you eat or drink something fattening after you have a bad day?

What would happen if you had a bad year?

Having what is 'important to' relates to being healthy and safe. When things that are important to you are missing, we often act in ways contrary to what is important for us.

Next slide

We All Wants Lives Where We are Supported & Contribute to Our Communities

How do **WE** achieve these goals?

Everyone wants lives where we are supported and contribute to our communities, so how do we achieve these goals for ourselves?

Take responses.

If no responses, ask the following questions:
How do we…

Stay healthy & safe on our own terms?

Have what/who is important to us in everyday life - people to be with, things to do, places to be?

Have opportunities to meet new people; try new things; change jobs; change who we live with & where we live?

Have our own dreams and our own journeys?

Next slide

Person-Centered Planning…

Intentionally moves from an approach geared toward fixing or solving problems, to one focused on:

- providing opportunities
- creating avenues for self-actualization
- personal freedom
- meaningful interdependence
- community involvement

Ultimately, PCP is adhering to a set of principles that value self-determination and personal dignity.

PCP purposefully moves away from fixing or solving problems to one that is focused on:

Providing opportunities and informing the person and their team of possible options so they can make an informed choice.
This could include living arrangements, employment, social networks and other services and supports

Creating avenues for self-actualization and self-expression

Promotes personal freedom

Enhances relationships and helps to build meaningful interdependence.
We are all interdependent, aren't we?

And helps to facilitate community involvement and positive valued roles.

Ultimately it builds on the natural (family members, friends) **and formal supports** (case managers/support coordinators, educators, etc.) **and community networks to support the individual.**

Next slide

Play A Credo for Support
https://www.youtube.com/watch?v=SKCxwDF-SrI

Please watch this video. It summarizes all of the values embraced by Person Centered Planning. It is titled, A Credo for Support by Norman Kunc & Emma Van der Klift, two well-known authors in the field.

Self-advocates inspired and read it in this recording.

In my opinion, it could not be said better.

Connect to you tube and show the video. 5 min 7 sec
http://www.youtube.com/watch?v=wunHDfZFxXw&feature=related

Wrap up: 2 Minutes

Ask: **Any comments/reactions?**

If anyone asks about Tracy Latimer, the person it was dedicated to, here is the story:
This was dedicated to Tracy Latimer, a young woman, girl really, whose father placed her in the family car in the garage with the motor running because he could not imagine his life would be worth living under the same circumstances. At the trial there was an outcry all over the country (Canada) for what do you think? Leniency.

End of section.

Next slide

The Planning Team

Roles & Expectations

Let's talk about the planning team.

Next slide

Having a planning team is extremely important in PCP because we are all interdependent.

Interdependence is a give and take relationship that

- **Allows us to be ourselves**
- **Supports growth**
- **And allows for flexibility**

It's a mutual dependence. All of us depend on others in our lives

- **To give advice and support, as well as**
- **Love, care and acceptance**

Next slide

Who To Invite
Use Relationship Map

Complete with member prior to meeting

Questions to ask:

- Who are you closest to?
- Who do you hang out with/spend most of your time with?
- Who do you talk to and/or get help/advice?
- Who cares about you?
- Who is important to you?

May give insight on who to include but always verify with the member

If there is a health care decision maker, they must be included in planning

AHCCCS Person-Centered Service Plan Pg. 1

You can use the Relationship Map to determine who's important to the member.
Some of the questions you might ask to get at the information are:

- **Who are you closest to?**
- **Who do you hang out with or spend most of your time with?**
- **Who do you to talk to?**
- **Who do you go to for help or advice?**
- **Who cares about you?**
- **Who is important to you?**

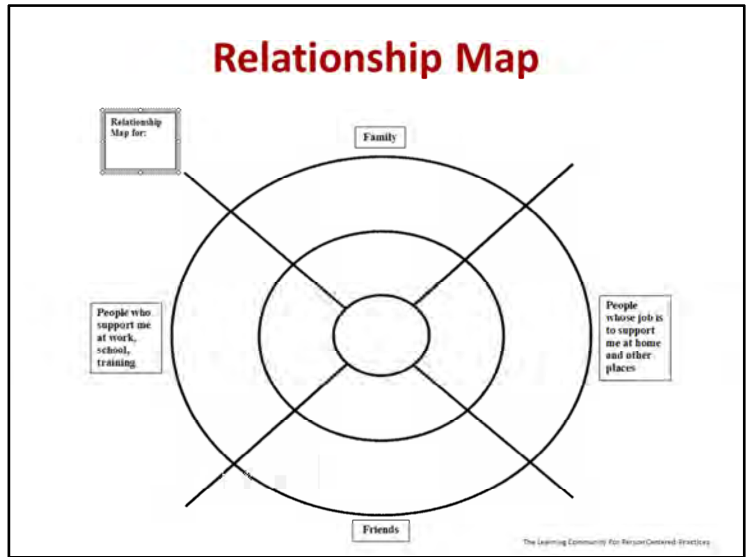
The map may give you insight on who to invite, but doesn't necessarily dictate it.

This is done from the perspective of the member – who are the people they know and care about.

- **Put the member's name in the center**
- **Fill out each section based on how close they feel to family members, friends, etc.**
- **Who is paid to provide support?**
  - **Your doctor**
  - **Whoever cuts your hair**
  - **How close do you feel to them?**

The information gathered on this relationship map can tell you a lot about the person.

Next slide



It's important that this information is verified by the member. This is from their viewpoint. Sometimes family members or residential providers may be upset about where they are placed on the circles, but the member's verification is essential.

Next slide

Who Might be on the Planning Team?

- **Member (always present)**
- Case Manager/Support Coordinator (always)
- Health care decision maker (always)
- Family members
- Close friends
- Service providers
- Natural Supports -
  - Co-workers
  - Neighbors
  - Faith based relationships
  - Anyone invested the member's wellbeing and success

AHCCCS Person-Centered Service Plan Pg. 1

Here are some of the people who might be on the planning team.
Review slide.

The member should always be present for the meeting. How can a meeting be person-centered if the person is not there?

The team may look a lot differently than it does now.

Next slide

How team members can contribute to the plan is documented on page 1.

Some may be able to attend in person or by phone on conference.
Touch base with the member prior to the meeting to find out who they want to come and what parts they can be present for.
Team members can provide info before or after the meeting if they aren't able to attend.

You may be calling team members after the meeting to follow up on items discussed.

Next slide

Partnerships and Experts

- All good plans are done in partnership
- Partnerships that work have agreed upon roles
- When developing plans, it is helpful to think about roles from the perspective of content experts and process experts

The Learning Community For Person Centered Practices

All good plans are done in partnership.
Partnerships that work have agreed upon roles.

It might be helpful to think about these roles broken down into *content experts and process experts.*

Next slide

Content Experts

People who have the information that goes into the plan

Know the details of:

- Important To
- Important For

The Learning Community For Person Centered Practices

Content experts know the details about what is important to and important for the member. Of course, the member is the main content expert!

Ask: **Who else might this be?**
Possible Answers:

- Family
- Direct Care Professionals
- Friends
- Program managers
- Therapists
- Medical professionals

The relationship map can help lead you to the content experts.

Next slide

Process Experts

- Understand HOW to develop plans with people
- Are skilled at recognizing which person centered thinking tool is helpful and when
- Are skilled at pulling out information from a conversational format

The Learning Community For Person Centered Practices

The process experts know how to develop plans with people.
They are skilled at recognizing how to obtain the necessary information and can pull information from a conversational format.

Ask: **Who might these people be?**

Answers:
Case Manager
Support Coordinator

Process experts are the plan facilitators.
They need to understand how to develop plans WITH people.

Next slide

Current Practice

- Who is sitting around the table when developing the service plan?
- What is needed to have a better mix of content "Experts"?

Ask:

What is the current practice?

Who is usually sitting around the table when developing the service plan?

What might need to change to have a better balance of "content experts?"

Next slide

Case Manager/Support Coordinator Responsibilities

Core responsibilities
- Ask member where they want to meet
- Complete Relationship Map with member and invite chosen people
- Facilitate meeting – use person-centered process & tools
- Inform team of known options available
- Follow up with team on action items
- Administrative duties

Use judgment and creativity
- Introduce topics that haven't been considered
- Brainstorm with team
- Find different ways to capture needed info
- Guide member to create vision for the future
- Work with team to find creative ways to reach goals
- Help team to discover all options
- Strategies to help team implement the plan

Not our paid responsibility
- Making decisions for member
- Complete action items assigned to other team members
- Determining the vision of the future
- Determining the goals for the member

This chart gives a good picture of the responsibilities of the case manager/support coordinator.

Core Responsibilities are those things you are required to do:
- **Asking member where they want to mee and who they want there**
- **Facilitating the meeting using person-centered skills**
- **Informing member and team about options**
- **Following up with team members on assigned action items**
- **Writing and distributing the plan**

You can use judgement and creativity:
- **Introduce new ideas**
- **Brainstorming to solve problems**
- **Using different ways to obtain the info you need**
- **Guiding the member to discover goals and dreams and working with the team on creative ways to make them happen**
- **Strategies used to implement the plan**

It is not your paid responsibility to:
- **Make decisions for the member**
- **Determine vision of the future or goals FOR the member**
- **Complete action items assigned to others**

Next slide

Roles & Expectations
Team Members

Content Experts – Know the details of:

- Important to
- Important for

Brainstorming with & supporting member to create a blueprint for success by:

- Sharing knowledge of personal experiences with member
- Increasing knowledge of available resources
- Supporting directions defined by the team
- Listening, being open to alternative ideas
- Being willing to contribute and take action

The member and the team are primarily the content experts who know the details of important to and important for.

The team is there to support the member in creating a blueprint for success by:

- **Sharing their knowledge of experience and resources**
- **Supporting the directions defined by the team**
- **Listening and being open to different ideas and**
- **Being willing to take action**

Next slide

Setting the Meeting When & Where

Be sure to ask the member:

- When they want to meet
- Where they want to meet
- Who they want to be there
  - What part of meeting can team members attend
  - Can information be obtained via email or phone

AHCCCS Person-Centered Service Plan Pg. 1

The first task – asking the member when and where they want to meet.

Next slide

Preparing For the Meeting

Ensure materials are in a language accessible to member & family/health care decision maker

- Arrange for needed interpreters
- Seek out information on family customs and culture
- Think about PCT tools/concepts that may be useful
- If at all possible, contact ahead of time to obtain current medical information
  - Meeting becomes a *conversation* about health

In preparation for the meeting, the SC/CM needs to ensure materials are in an accessible language for member and their family/health care decision maker.

- **Arrange for interpreters**
- **Learn about family customs and culture**
- **Think about any PCT tools or concepts that may be useful to obtain information.**

It's helpful to call prior to the meeting to obtain current medical information. That frees up time to have a *conversation* about health and how members can take more leadership in their own health care.

End of Planning Team Roles and Responsibilities Section.

Next slide

Facilitating a Person Centered Service Plan Meeting

Getting Started
Working with People
Dealing with Situations

What do you think facilitating a person centered service plan meeting involves?

Next slide

4 Stages of Planning and Implementation

1. Think about what you want to learn
2. Gather information
3. Develop a vision and desired outcome(s)
4. Use the service plan to document findings and develop action plan

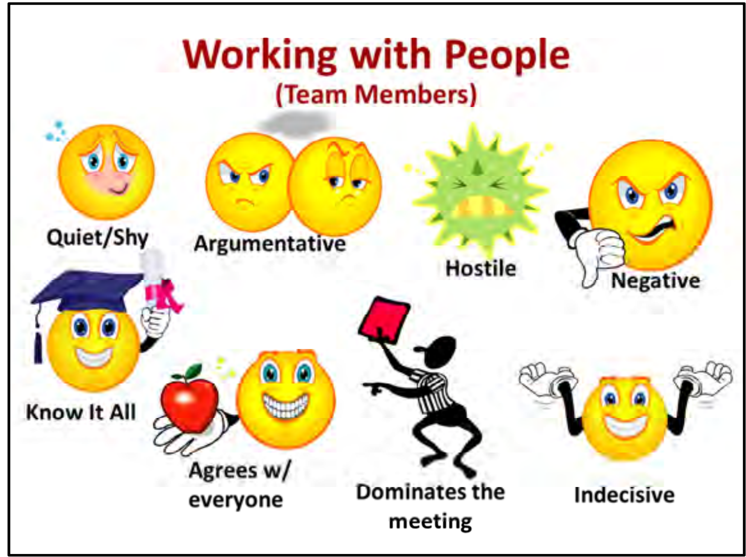
There are 4 states of planning and implementation of a plan:

1. **Thinking about what you want to learn**
2. **Gathering the information**
3. **Developing a vision and subsequent desired outcomes**
4. **Using the service plan to document your findings and develop the action plan**

Plans that work begin with thinking about what you want to accomplish; then figuring out the things you need to learn that will help you get there *and* how to learn them.

Plans that work are not annual events; they are part of an ongoing cycle of learning and acting on what you learn. It should be a living document.

Next slide



You will be working with a variety of individuals, teams and team dynamics on planning teams.
Briefly review characteristics on slide

Now we're going to do an activity to help you learn how to deal with different personalities.
We are referring to team members other than the member.

Divide into small groups depending on number of students (8 activity types). Once divided have them move to an area of the room together with their participant's guide, flip chart and markers. If you have a large class, you may have to have more than one group working on the same personality types. You should have 2 sets of the cards.

Click for activity instructions
Next slide

Working with People

On each card is one of the types of behavior types listed on the previous slide

1. On your flip chart paper list your two behavior types
2. Next list at least 2 behaviors that will let you know that this is who they are
3. Come up with some strategies to neutralize their behavior and incorporate them into the discussion

We're going to hand out cards with different personality characteristics. Each group will get (however many cards to be sure they are all covered) **cards.**
Hand out the cards.
Also give each group 2 pieces of flip chart paper.

On each card is one of the types of behavior types listed on the previous slide.

1. **On your flip chart paper list your groups assigned behavior types**
2. **Next list at least 2 behaviors that will let you know that this is who they are**
3. **Come up with some strategies to neutralize their behavior and incorporate them into the discussion**

You will have about 10 minutes and then we will report back to the whole group. You may begin now.

Give them a warning at 5 Minutes.

Give them another warning at 1 Minute.

Ask if they need more time. If they do, give 3 additional minutes.

Time is up. Let's see what you all came up with. You may want to write down what's discussed by the group in your participant guide for your future reference.

Ask the following to process the activity. If you have more than one group working on the same personality, have them take turns reporting the information so they both get to share:

Ok, who had Quiet & Shy?

- **How are you going to know that they are Quiet & shy?**
- **How are you going to draw them in?**

Who had Argumentative?

- **What clued you into the fact that they have that label?**
- **What strategies might you use?**

How about Hostile?

- **What does "hostile" look like?**
- **What can you do with Hostile?**

Ok, How about Negative, who has Negative?

- **Describe Negative.**
- **What strategies did you come up with?**

Let's hear about the "Know it all".

- **How can we include him/her?**

Let's take a look at Agreeable.

- **Why might someone who agrees with everyone make team consensus difficult?**
- **What strategies might be helpful?**

So who had the Dominator?

- **What does their meeting look like?**
- **What can you do to change that?**

Lastly, we have Indecisive folks.

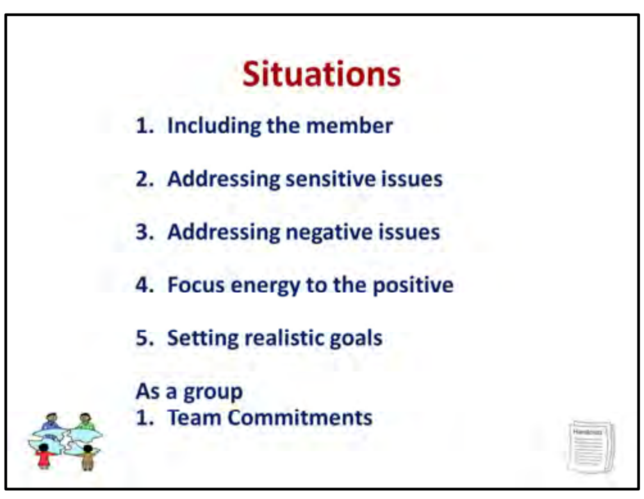
- **What does their meeting look like?**
- **What can you do with them?**

Handout - Dealing with Challenging Behaviors
Be sure to pick up the cards from the groups

Nice job everyone! Now we are going to take a look at situations that you may encounter while facilitating a PCP.

This may be a good time for a break. Move chart paper and prep for next activity.
When back –

Next slide



Handout - Dealing with Various Situations

You are going to face a variety of situations while facilitating PCSP meetings. We are going to spend a little time focusing on a few situations that seem to crop up enough to be at least irritating.

Break into small groups for the 5 scenarios. If a large group, you may have to have more than one group working on the same situations.

Once in their groups, give each group flip chart paper and markers and an area of the room to work w/ their groups.

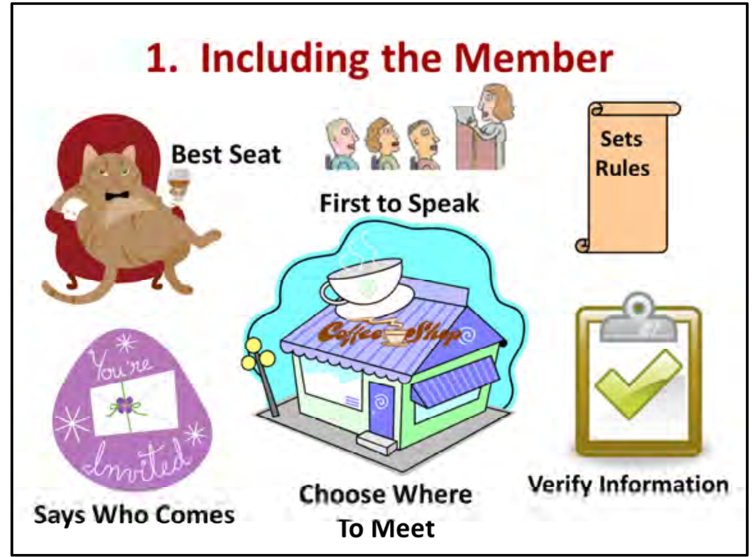
I am passing out (however many needed to cover the 5 situations) **cards per group. On each card are situations you may encounter as you facilitate plans. On your Flipchart paper, please list your situation by name & number and ways to address the situations listed. We've also given you a handout with possible questions to answer for each situation.**
You will have 10 minutes. Please begin.

Give a 5 minute warning. Give a 1 minute warning. If they need more time, you can add 3 minutes.

Have the groups report out in order of the situations 1-5 and reveal the slide for their situation after they report.

If you have more than one group working on the same situation, have them take turns reporting the information so they both get to share.

Next slide



Ask the following to process the activity:
Which group had "Including the Member?" What did you come up with?

After the group shares, click through animation for 6 examples.

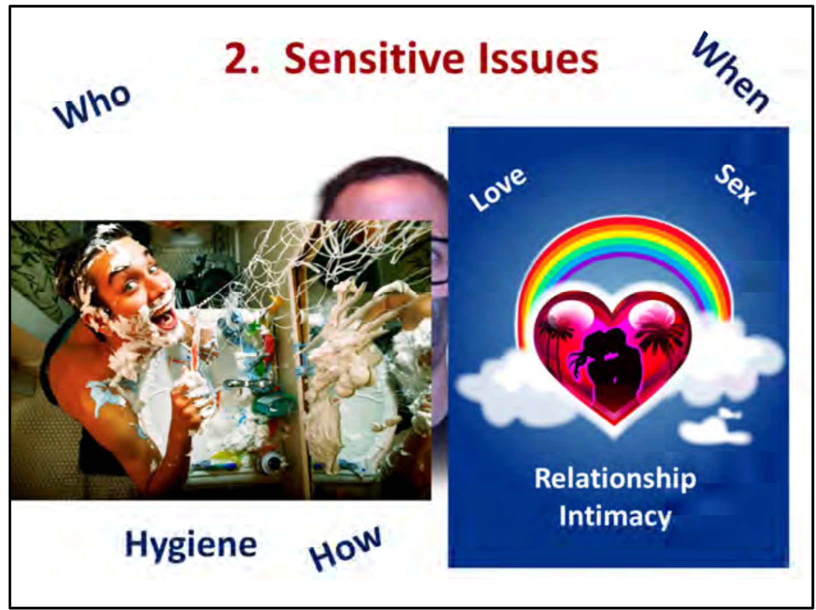
Could any of these be affected by culture?

Make a comments about below if nobody brings up:

Best seat –Think about where someone wants to sit, but depending where the meeting is held, consider power dynamics .
Where do they feel comfortable, Make sure all voices are valid. How the room is setup can set the tone of the meeting.

Verify information – even people who don't use words to communicate can do this. Be aware of their reactions and body language when team members are talking.

Next slide

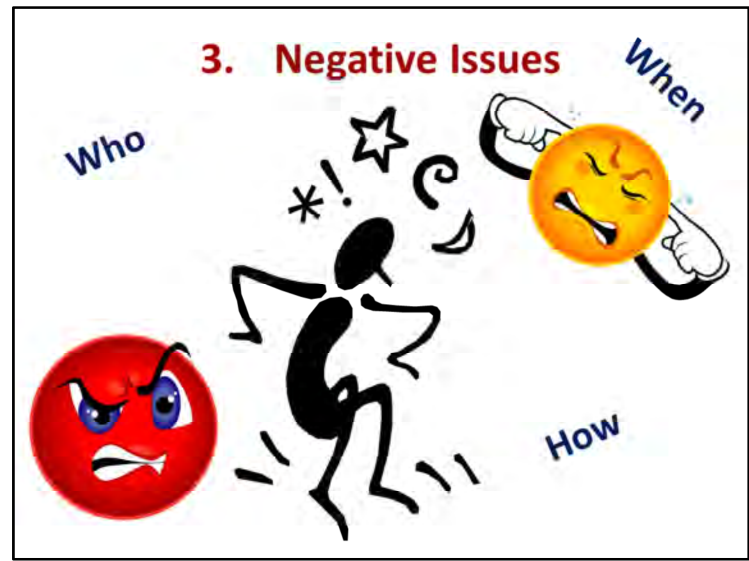


Ask:
Which group had "Sensitive Issues"? What did you come up with?

After the group shares, click through animation for 6 examples.

If nobody mentions say:
Not all team members need to be present to talk about everything. If there are sensitive issues, find out who the member wants to have present when they are discussed.

Next slide



Ask:
Which group had "Negative Issues"? What did you come up with?

If nobody mentions, comment:
Is there a way to couch negatives in a positive way?

Next slide

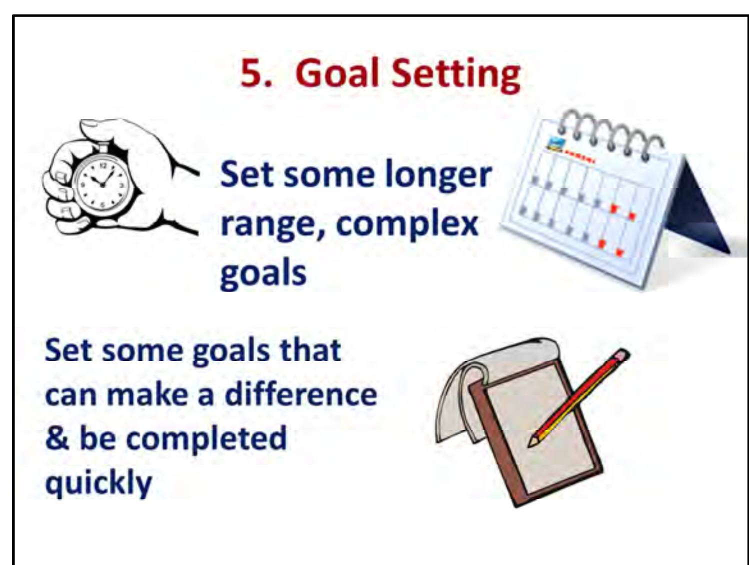
Ask:

Which group had "Focus on the Positive"? What did you come up with?

After the group shares, click once for animation for examples.

Setting a positive tone for the meeting is so important.

Next slide



Ask:

Which group had "Goal Setting"? What did you come up with?

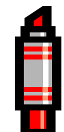
After the group shares, click through animation for 2 examples.

If not mentioned:

Achieving success quickly is very motivating for the member and the team.

Next slide

Let's do "Team Commitments" together. What are some ideas you have?

 Use flipchart paper for 6th situation.

You can use the questions below to spark discussion. Write responses on flipchart paper.

1. **What are some ideas for working with team members that make commitments yet never follow through on them?**
2. **How can you encourage participation from team members that refuse to volunteer for any action items during the meeting?**
3. **How would you ensure equal participation and commitment among all team members during the planning process?**
4. **What strategies could you employ with team members who never show up for the meetings?**

After the group shares, click for animation for examples.
Great job everyone!

Next slide

Ask: **Can you name some of the roles of the facilitator.**

You could have candy, call on people and toss candy for correct answers.

- Coach
- Gate keeper
- Entertainer
- Advocate
- Community developer
- Entertainer
- Creative force
- Recorder
- The glue for the team
- Discoverer

Click through animation.
You can mention ones not covered.

Next slide

Facilitating The Meeting

- Assist to identify relevant participants
- Provide unbiased facilitation
- Establish and keep ground rules
- Encourage input from all team members
- Keep it positive and member focused

Always include the member

In your role as a facilitator, it is your job to build the structure of the experience and planning process.

- **Help the member identify team members**
- **Remain unbiased in facilitation**
- **Establish and enforce ground rules**
- **Encourage participation of all team members**
- **Keep it positive – focused on the member**

Next slide

GROUND RULES

Be Respectful
- In the meeting
- In the plan
- In future efforts

No Jargon
- No clinical or human service speak
- Use everyday language
- Remember who plans are written with

No Obsessing
- 5 minute rule
- "Parking" issues that are not resolved

No Fixing
- People are not broken
- Good solutions are rooted in listening

The Learning Community For Person Centered Practices

It's a good idea to have these ground rules and review before each meeting.

First point:

- **Point out that to "be respectful" is the over arching rule.**
- **Let people know that regardless of where they are in learning this process they are unlikely to do harm if they keep this in mind.**
- **Also let them know that when something does not feel respectful and they are not sure what to do they should call a break, temporarily stop the process. If they cannot figure out how to have a respectful process do not plan with that person until you have an idea about a respectful way to proceed.**

Second point, no jargon:

- **What are the exceptions to the no clinical or human service speak rule?**
- **Clinical jargon/human services speak should only be used when describing medical issues or other such topics where there are not applicable everyday terms that can be used.**

No obsessing:

- **Don't forget the 5 minute rule and to "park" issues that are not resolved.**

No fixing:

- **People are not broken.**
- **We can find good solutions if we are listening.**

Next slide

General Rules for Writing Plans

- Use complete thoughts
- Use common, everyday language, not acronyms
- Include detail and/or examples that someone new will understand

The Learning Community For Person Centered Practices

Here are some general rules about writing plans.

- **Use complete thoughts, but not necessarily complete sentences.**
- **Use common, everyday language rather than the terms and abbreviations used by government and community agencies.**
- **Each item listed has enough detail and/or examples that someone new in the person's life will understand what is meant.**

Next slide

Facilitating The Meeting

- Help member and team develop realistic vision for the future
- Break outcomes into achievable steps
- Identify barriers & brainstorm solutions
- Identify resources & how best to use them
- End each meeting with Action Items
- Begin meetings with follow up on Action Items

AHCCCS Person-Centered Service Plan Pgs. 3, 13

As a facilitator you will lead the team in developing a realistic vision for the future, and to set up the outcomes into achievable steps.

You will help the team identify barriers and find solutions, as well as discovering resources.

Begin and end each meeting with action items.

Next slide

Cultural Considerations

- Planning should reflect cultural considerations of individual
- Consider team/family dynamics
- Know
  - How the member and family make decisions
  - How culture relates to different situations
- Developing a realistic vision of the future
  - May need to frame in a different way, different terminology
- If hitting a roadblock, consider cultural differences

Planning should reflect cultural considerations of individual and always consider team/family dynamics.

- **Who do you contact to schedule meetings?**
  In some cultures it might be the "man of the house."

Know how the member and family of choice make decisions and how culture may relate to different situations.

When developing a realistic vision of the future, you may need to use different terminology.
Learn the terms they use to describe the diagnosis or condition.

If hitting a roadblock, cultural differences may be a factor. May be due to cultural differences in thinking around a particular issue.

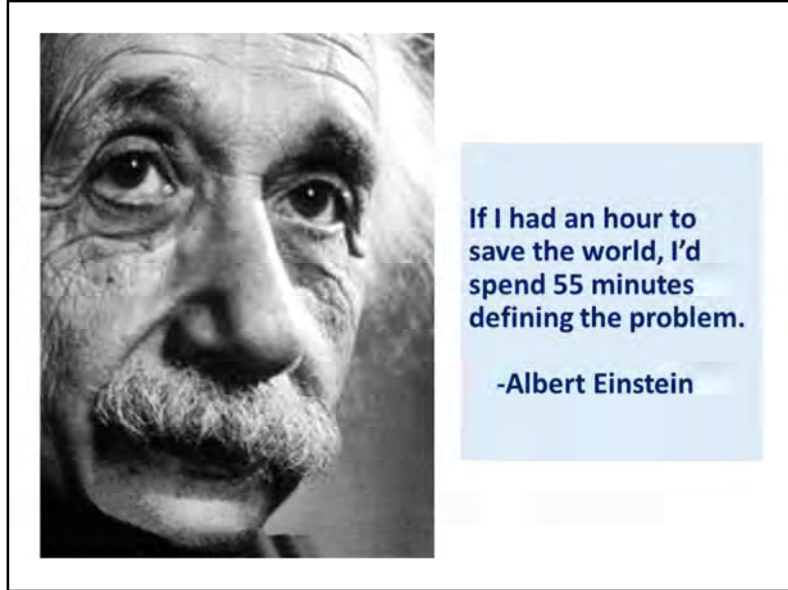
Next slide

We tend to have a "fixing" compulsion – that gets in the way of critical thinking.

The result is solutions that are not creative.

We have to help the team get past the "fixing" compulsion by asking: What do we know and what do we do?

Next slide



The more time you spend defining the problem… the better the solution.

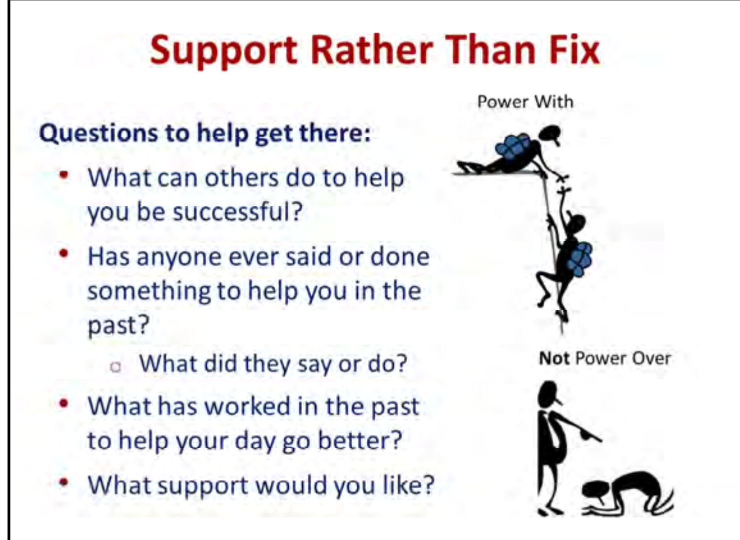
In places where it feels like there is never enough time and there is always a crisis, stopping to think is not a luxury, it is critical.

This is part of how we can make the decisions that avoid the crises.

The more time we spend understanding an issue – the better chance we have of coming up with a good solution.

Read quote on the slide:
Albert Einstein said, "If I had an hour to save the world, I'd spend 55 minutes defining the problem."

Next slide



Ask: **Support rather than fix – what do you think that means?**
Take some responses

Click
What are some questions to ask to help get there?
Take responses.

Click
Here are some additional questions.

Next slide

Support is Required for Growth

Growth occurs where it feels safe

Where

- Learning is supported
- Practice is encouraged
- Effort is rewarded
- Success is celebrated

SUCCESS

Growth occurs where it feels safe.

Where

- **Learning is supported**
- **Practice is encouraged**
- **Effort is rewarded**
- **Success is celebrated**

Next slide

7 Questions Need Answers

1. What is important to the person?
2. What is important for the person?
3. Is the connection between important to and for addressed?
4. Is there a "good" balance between important to and important for?
5. What does the person want to learn & what do we need to learn?

To achieve the balance, we need to know:

6. **What needs to stay the same (be maintained or enhanced)?**
7. **What needs to change?**

The Learning Community For Person Centered Practices

Be sure the plan reflects the answers to these questions for each member.

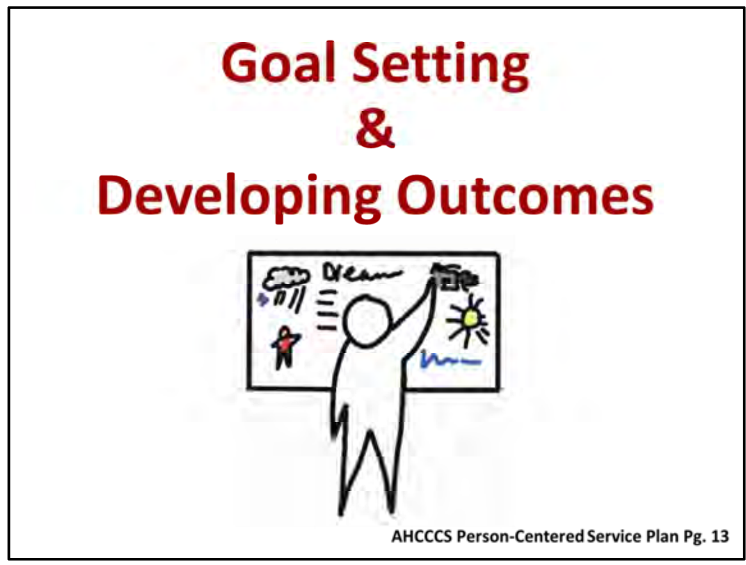
1. **What is important to the person?**
2. **What is important for the person?**
3. **Is the connection between important to and for addressed?**
4. **Is there a "good" balance between important to and important for?**
5. **What does the person want to learn & what do we need to learn?**

To achieve the balance, we need to know:

6. **What needs to stay the same (be maintained or enhanced)?**
7. **What needs to change?**

End of Facilitating a Person Centered Service Plan Section.

Next slide



Let's talk about developing goals and outcomes.

Next slide

Vision of the Future

Everyone has an idea of where they would like to see themselves in the future –

- Where they would like to live
- How they spend their time, and
- With whom they want to share their life

Individuals' interests, preferences, hopes, and dreams should **drive** the goals and action items in their plans.

AHCCCS Person-Centered Service Plan Pgs. 3, 10-13

Ask:
Vision of the Future – What does that mean to you?
Take some responses.

Click
Everyone has their own idea of what they would like their future to be:
Click through each one

- **Where they would like to live**
- **How they spend their time, and**
- **With whom they want to share their life**

Individuals' interests, preferences, hopes, and dreams should drive the goals and action items in their plans.

Dr. King said, *"I have a dream."*
He did not say, *"I have an annual plan and quarterly goals and objectives."*

Next slide

Creating A Good Life

Everyone has own definition of a "good life"

Discovering this is the main task of the PCSP process

Case Manager/Support Coordinator's job to:

- Make sure the member knows all options/resources available to
  - Make informed choices
  - Have positive control for the life they want
- Assist member to develop personal goals
  - Short range and long range
- With the team, develop an action plan to help member achieve goals

AHCCCS Person-Centered Service Plan Pgs. 3, 10-13

Each person has their own definition of what creates a "good life." Discovering this is the main task of the PCSP process.

As the Case Manager/Support Coordinator, it is your job to make sure the member:

- **Is aware of full range of options and resources available to make informed choices and have positive control for the life they want.**
- **Help them to develop their personal goals – both short range and long range.**
- **Along with the team, develop the action plan to help the person achieve their goals.**

Next slide

Domains of Life to Consider
Basics

- Housing & Living Arrangement
- Money & Resources
- Health Care & Wellness
  - Physical & Emotional
- Safety & Security
- Decision-Making Support
  - Ability to make informed decisions

Here are some of the basic domains of life to consider:

Housing and Living Arrangement

- **Where and with whom**

Money and Resources

- **How they earn money**
- **Resources and benefits**

Health Care & Wellness, both Physical & emotional

Safety and Security

How to stay safe from financial, emotional, physical or sexual harm

- **Assistance with finances if needed**
- **Personal safety devices**
- **Supervision as needed**

Decision-Making Support

- **Ability to make informed decisions**
- **Power of attorney if needed**
- **Potentially guardianship**

Next slide

Domains of Life to Consider Quality of Life

- Daily Life & Employment
- Relationships
  - Family, Friends, Community Contacts
- Healthy Living
- Community involvement
- Spirituality
- Self-determination & Self-advocacy
- Supports & Services

AHCCCS Person-Centered Service Plan Pgs. 3, 10-13

Ask: **What are the domains to consider related to quality of life?**
Take responses

Click through each bullet:
Daily Life and Employment
Meaningful Day
Employment & Retirement – what type of job/career do they want
Education
Social activities

Relationships
Family, friends, partners, community contacts
How will they make connections?

Healthy Living
Exercise and nutrition

Community Involvement
Leisure activities
Integrated activities
Voting
Community groups
Interests and opportunities for learning & personal growth

Spirituality
If they follow a specific practice/religion, where and with whom?
How to connect with others?

Self-determination and Self-advocacy

Supports and Services

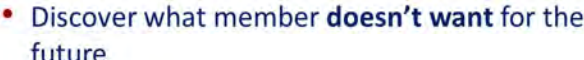
Supports to enable person to live the life they want

Next slide

Creating a Vision of a Good Life
Informed Choice

- Reflect on Domains of Life and Quality of Life Considerations
- Explore options
  - What is possible
  - What is desirable
  - Understanding trade-offs

- Vision of kind of life the member **wants**



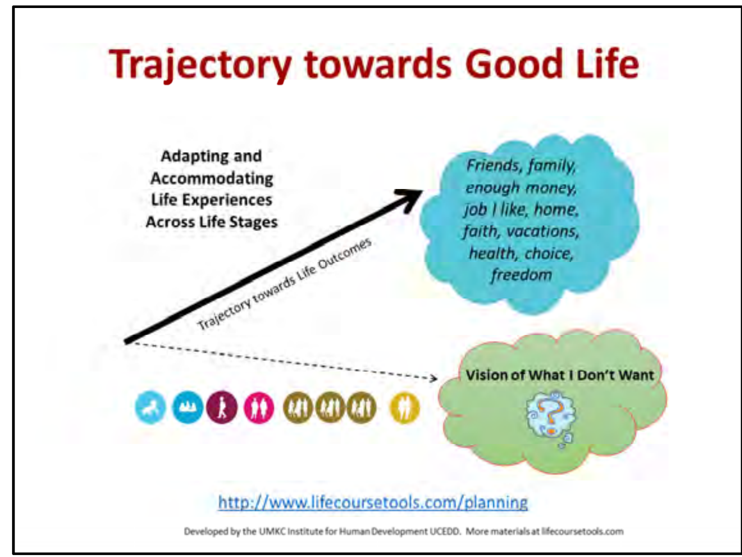
- Discover what member **doesn't want** for the future

AHCCCS Person-Centered Service Plan Pgs. 3, 10-13

After exploring the members' preferences regarding the domains of their life, it's time to explore with the member the variety of options regarding what is possible and desirable, and understanding the tradeoffs.

People may not always be able to verbalize or explain what their "good life" is. However, I imagine everybody can tell you what they DON'T want. Sometimes identifying the future they *DON'T* want can help you discover the future the they *DO* want.

Next slide



People with disabilities and their families usually want the same types of things you and I want. They "get" the idea of what the good life is - we just don't usually ask them!

Ask: **What kinds of things do you think people with disabilities and families would say they DON'T want?**
Take a couple of responses.

Sometimes you need to start there – they may not know what they want (because they may not know the options/possibilities or thinking in terms of disability services), but they almost always can tell you want they don't.

The trajectory is the path that will either lead you toward the good life or toward things you don't want.

Here is a worksheet from the LifeCourse Toolkit. The link is on the slide and is also in our resources.

Next slide

Defining a Good Life

- Individualized for each person
- Leads to creating their vision for the future
- Is informed by knowing what's "***Important To***" & "**Important For**" the person
- Can be discovered by learning **what they don't want** as well as by what they want

AHCCCS Person-Centered Service Plan Pgs. 3, 10-13

The definition of a good life is different for each person. Discovering this helps in creating their vision for the future.

The definition of a good life is informed by knowing what's "Important to" and "Important for" that person.

And as I said previously, it can be discovered figuring out what they don't want.

Next slide

A goal is related to helping the person to have a good life and is connected to their future vision.
It addresses what the member wants to do.
It has an observable and measurable end result – something that lets us know it's been achieved.

Goals can be an area in the person's life they want to work on, or it could be something already in their life that they want to remain the same.

Next slide

Goals – Outcomes – Objectives

- A **goal** is something the person wants to achieve
  - An end result
- **Outcomes** are identifiable, measurable statements that indicate the goal has been achieved
- **Objectives** are specific, measurable action steps to reach a goal
  - **What needs to be done**

AHCCCS Person-Centered Service Plan Pg. 13

Here's a further breakdown:

A Goal

- **Something the person wants to achieve.**

Outcomes

- **Specific, measurable statements that let you know when you have reached your goals.**
- **Outcome statements describe specific changes in your knowledge, attitudes, skills, and behaviors you expect to occur as a result of your actions.**
- **Good outcome statements are specific, measurable, and realistic.**

Objectives

- **Specific and measureable action steps to reach a goal.**
- **They tell us what needs to be done.**

Next slide

Goals – Outcomes – Objectives

- Can sometimes be identified by examining "What works/makes sense" & "What doesn't work/make sense"
- Can be informed by information obtained during discussion about Preferences & Strengths, Individual Setting, Daily Life
- Can be related to what needs to stay the same
  - Either maintained and/or enhanced

AHCCCS Person-Centered Service Plan Pgs. 3, 10-13

Goals, outcomes and objectives can often be identified by looking at "What works/makes sense" & "What doesn't work/make sense.
Helps determine what needs to change and what needs to stay the same.

They can also be guided by information obtained when discussing

- **Preferences & Strengths**
- **Individual Setting**
- **Daily Life**

If member expresses dissatisfaction with aspects of those parts of their life, it opens the door to discussions about what they would like to change/work on.

Goals can also reflect what people want to stay the same. This may be particularly important when working with elderly people whose health may be deteriorating. The goal may stay the same in terms of the desired quality of life, but the outcomes and/or objectives may change as their functioning declines.

Next slide

Goals – Outcomes – Objectives

Member goals **DO NOT** include:

- Goals determined solely by the provider, without member input
- Goals automatically generated based on patient conditions or risk factors
  - Unless identified by the member

These items can be placed on the Action Plan and assigned to a team member

AHCCCS Person-Centered Service Plan Pg. 21

It must be said that member goals DO NOT include:

Goals that have been determined by the provider without member input.

Goals automatically generated based on patient conditions or risk factors, unless that has been identified by the member.

These items can be discussed and placed on the Action plan and assigned to a team member.

Next slide

Outcome Development Principles

- **Functional/Meaningful Outcomes are:**
  - Best derived from questions related to participation in daily routine.
  - Are based on assessed needs considering strengths & preferences
- **Functional/Meaningful Outcomes May OR May Not need to be supported by a paid service**
- **Be sure to explore other sources of support**

AHCCCS Person-Centered Service Plan Pgs. 3, 10-13

Functional/Meaningful Outcomes are best derived from questions related to the person's participation in their daily routine.

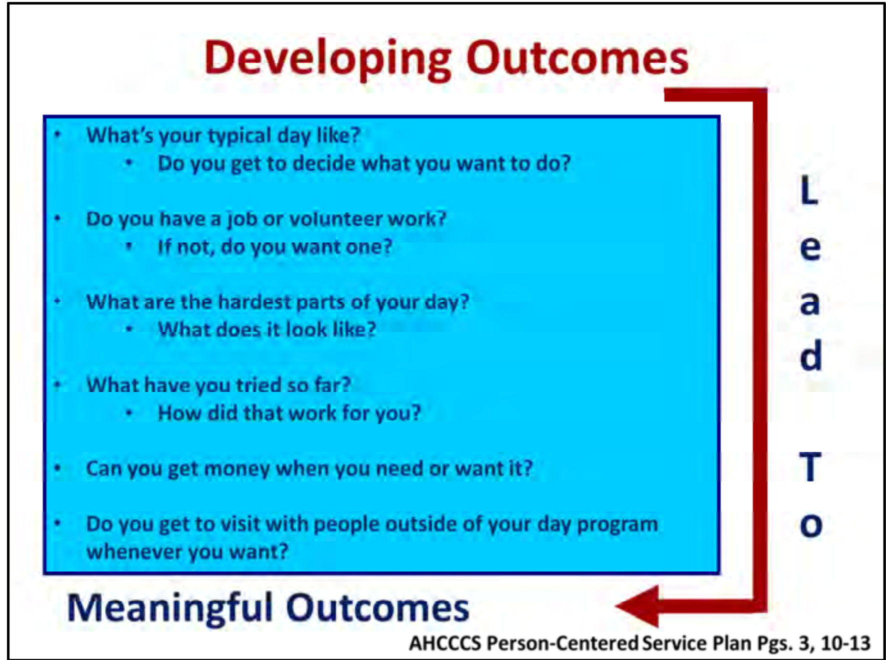
They are also based on assessed needs, while considering the member's strengths and preferences. They are not written to justify a service.

The outcome is written to help the person have the life they want. They should be based on helping them obtain a good life.

Give an example to illustrate. A possible example:
I heard a story about a friend's grandmother. She had struggled with her weight and arthritis for many years. Although she would talk about taking action, she never went on a diet or exercised, etc.
One item on her "bucket list" was to go to Greece. Her son and his wife said they would take her, but they were concerned about her ability to do the walking needed to visit all the ancient sites. That was the motivation she needed to address her health issues! She started eating more healthily. She started walking daily, and gradually built up the distance and time she walked, therefore building up her stamina. She achieved her goal of being able to walk for 20 minutes! She was able to go to Greece and experience it the way she wanted to.

Functional/Meaningful Outcomes May OR May Not need to be supported by a paid service. Be sure to explore other sources of support.

Next slide



Outcomes can fall right out of the interview. Typically you can "get at" functional and meaningful outcomes by asking the questions, "What works in your day? What doesn't work?" or "What is the best part of your day? What have you tried so far?"

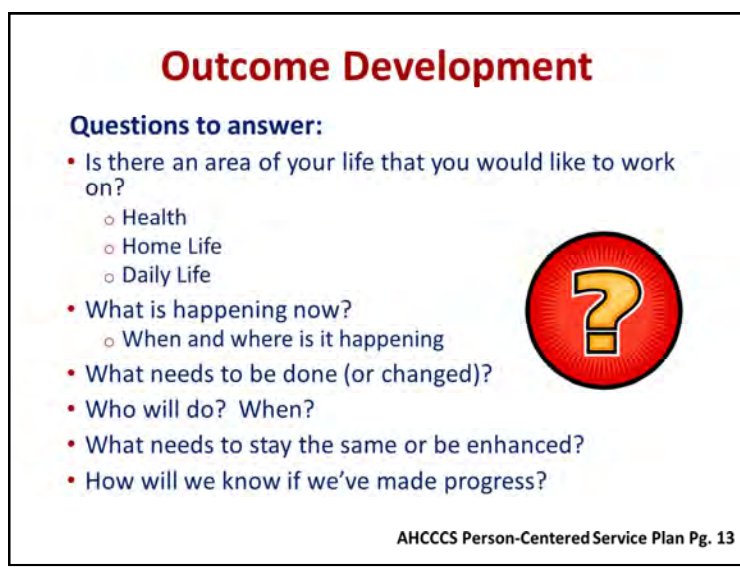
Listed here are some of the prompting question on the AHCCCS Person-Centered Service Plan.
Read a couple.

If you list the tasks someone can do and not do, or their strengths and needs and not look at how that impacts their day, you risk losing the functionality of the outcome.

Focus on how does working on a particular outcome make their life more successful *for them.*

What ways can the person be supported so that they can better participate in their day, home, community?

Next slide



Other questions to answer might be:

- **In there an area of your life you would like to work on and/or would like to be different?**
- **What is happening now?**
- **What needs to change?**
- **What needs to stay the same or be enhanced?**
- **Who will help support the change and when?**
- **How will we know if we've made progress?**

Next slide

Teams sometimes select CORE Responsibilities as Habilitative Outcomes. Core responsibilities are things that are a part of the staff's job, something they should already be doing.

Outcomes should be related to something the individual is:

- **Interested in**
- **Enhances quality of their life**
- **Assists the member with the daily routine**
- **Is a positive, functional activity that has meaning for them**
- **Increases or maintains independence as long as possible**

Next slide

Examples of a Goal and Outcome

Anna's Goal
- Anna wants to be a chef (Anna is in high school)

Outcome
- Anna will have a job in a restaurant

Objectives
- Anna will take a cooking class to learn about food preparation
- Anna will get a food handler's card

Harry's Goal
- Harry wants to continue living with his daughter & family (he has had several falls)

Outcomes
- Maintain Harry's current quality of life and independence In family home

Objectives
- Explore durable medical equipment & home modifications for stability
- Rule out any new/additional health concerns related to falls

AHCCCS Person-Centered Service Plan Pg. 13

Here are some examples of goals and outcomes.
Review slide.

Next slide

Working/Not Working

Negotiation tool

- Everyone must feel listened to
  - Accurately reflect perspectives
- Start with common ground
  - Those things all parties agree aren't working
  - Things that need to stay the same/enhanced
- Remain unconditionally constructive
- Done in partnership

Reflects current reality

- What is working now, not what would or could work
- Focus on a specific issue or area of life

The Learning Community For Person Centered Practices AHCCCS Person-Centered Service Plan Pgs. 3, 10-13

The working/not working tool can be used as a negotiation tool to inform goal setting, as well as the action plan.

When doing this analysis:

- **Everyone must feel listened to.**
- **You must start with common ground.**
  - **Those things that all parties agree aren't working – that's where change is most likely occur.**
  - **Those things that are working well and need to be maintained.**
- **The facilitator of the discussion is unconditionally constructive.**
- **Developing the goals and action plan is done in partnership.**

The plan should reflect the current reality:

- **What is working now, not what would or could work.**
- **Focus on a specific issue or area of life.**
- **Important to identify things that can realistically be accomplished. These may also be things that can be achieved quickly.**

Next slide

Working/Not Working

Peel the onion
- Always ask the question behind the question
- Dig deeper to find more meaningful information

Bridge to action planning
- What needs to be maintained/enhanced?
- What needs to change?

The Learning Community For Person-Centered Practices

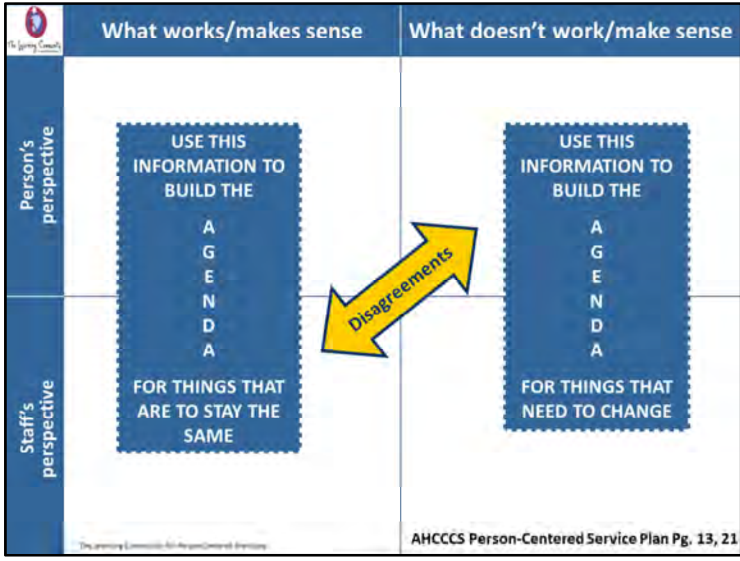
AHCCCS Person-Centered Service Plan Pgs. 3, 10-13, 21

Peel the onion
- **Always ask the question behind the question**
- **Dig deeper to find out more**

It can be a bridge to action planning
- **What needs to be maintained/enhanced?**
- **What needs to change?**

Be sure the plan is clear and uncomplicated.

Next slide



To help with action/goal planning:
The left hand column helps with identifying those things that you wish to maintain or enhance.
The right hand column shows things that need to change.

This illustrates what I'm talking about.
Disagreements often turn up on the diagonals.
This has 2 of the core principles of negotiation built into it –

> **If you have carefully written down everyone's perspective so they feel listened to.**
> **If you point out where the same items appear in the same column, but different perspectives, you have started with common ground.**

The case manager/support coordinator remains neutral in the process.

Next slide

	What works/makes sense	What doesn't work/make sense
Julie's perspective	• Shopping for favorite things • Having lots of jewelry and no one getting into them without my ok • Having my sister Joanne in my life • Lots of blue, red and black clothes • Polished nails, many colors & layers • Living with Teddy, the Yorkshire ⇨ Sleeping on my bed at night ⇨ Snacks from my plate ⇨ In my lap when I watch TV	• Staff don't let me drink what I want • Teddy leaving me during mealtimes • Staff not letting me buy things I want
Staff's perspective	• Favorite people doing activities with her, especially John Dandy • Keeping Julie from falling – reminders to use her walker • Level blood sugar - staff knowing signs of low and high blood sugar • Joanne is active in Julie's life • Planning before she goes shopping	• Julie is less steady on her feet and falling more than she used to • If you don't make a plan with her before shopping, she will want to buy more than she has money for – Julie may get very upset which can alter her blood sugar • Julie gives Teddy food off her plate

Remember Julie's story? We're going to revisit it to talk about how to use Working/Not Working as a negotiation tool and to guide goal setting and action planning.

Ask: **Who do we need to negotiate and work with to find out what works for the member?**

Possible responses:

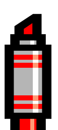
- Staff
- Maybe sister?

So it's about who really has the power to change the situation.

Activity:

This works best in small groups. If the participants are sitting at tables, have them work with others at the tables. If in another setting, break them up into small groups. **Work as a group for this activity. We'll give you 5 minutes to discuss.**

Look at the Working/Not Working for Julie and find at least one thing that needs to remain the same and one thing that needs to change. We will do the next step together as a group.



Take a piece of flip chart paper and draw a line down the middle. Head columns with "Needs to stay the same" and "Needs to change."

When 5 minutes are up:

Let's report out on what you decided.

Have each group say what they came up with and record in the appropriate column.

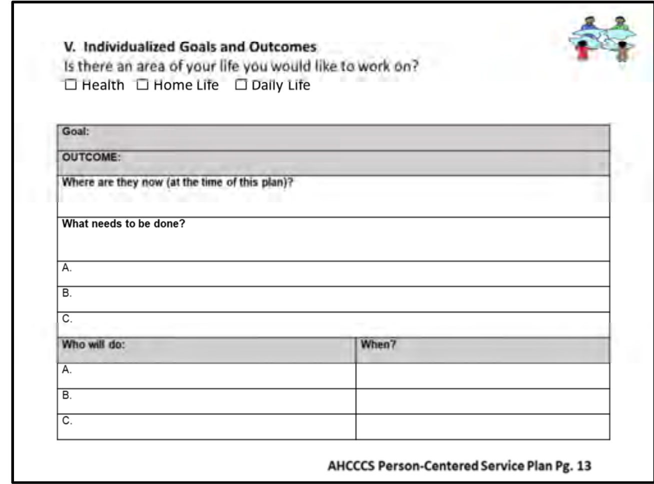
Using these identified items, what would be some potential desired goals?

Record on new flip chart sheet.

OK, great!

For the next phase, work with your group to develop a goal and outcome based on the things we came up with. ***Remember these are personal goals for Julie, so should be worded from her perspective.***

Next slide



V. Individualized Goals and Outcomes

Is there an area of your life you would like to work on?

☐ Health ☐ Home Life ☐ Daily Life

Goal:	
OUTCOME:	
Where are they now (at the time of this plan)?	
What needs to be done?	
A.	
B.	
C.	
Who will do:	When?
A.	
B.	
C.	

AHCCCS Person-Centered Service Plan Pg. 13

You will find a blank copy of the goals and outcomes page in your workbook in the Activity Sheets section. You will be using this to do the next exercise.

Write the goal in a holistic fashion.

Include:

- **Where they are now**
- **What needs to happen, and**
- **Who will be responsible for making sure it happens**

Give 10 minutes.
Have groups report out. You can record their information on a flip chart paper if you want.

When everyone has reported out:

When developing goals, include some they can achieve quickly. This creates more motivation.

Getting more information about something can be an action item to achieve the identified goal.

Look at goals that are not tied to a particular program or service. We aren't looking for how to change programs or make a program or service work better. The goal is related to improving the person's life.

Remember that people will do more things that are important for them if there's some important to included.

You would then create the steps to meet her ultimate goal.

Do you want to hear what happened to Julie?

The Teddy plate worked, until Teddy put on weight. They went to the vet and were told Teddy could have green beans, so he lost weight. When the case manager came back to visit, she found Teddy locked up in the other room again.

Why do you think this happened? (Pause for some responses).

He was locked up because staff changed and no one had written down this great idea.

Moral: How often do we have great ideas, get everyone on the same page so we don't write it down anywhere, and then we all leave the job? If we really want this great work to continue, it needs to be recorded and passed on.

Please note within the Goals and Outcomes page in the AHCCCS Person-Centered Plan document that you can add more goals and outcomes to the form.

Next slide

Identifying Non-Paid "Natural Supports"

- Look to the person's relationship map
- Who is willing/able to do what tasks
  - Family members
  - Friends
  - Church
  - Work
- Community involvement can expand the circle of support

AHCCCS Person-Centered Service Plan Pg. 16

Ask: **How do you identify natural supports?**
Take responses.
Click through and review.

Next slide

- Never too early to expand networks
- Need more eyes, ears, voices, feet, and hearts
  - **Keep adding people of all ages because some will drift off**
- Informal non-paid supports may be in unexpected places

We ASK people to do more

Learning how to “ask” is an important skill!

AHCCCS Person-Centered Service Plan Pg. 16

Ask: **What type of goals may be created around building networks and relationships?**

Possible responses:

Developing or maintaining relationships
Finding a significant other or companion
Getting married or having a long-term relationship

Click
We should be encouraging members and families to expand their networks. The more eyes, ears, voices, etc. the more support the person has.

Click
Informal non-paid supports may come from unexpected places.

Click
The best way to know what people are willing to do is to ASK.

Next slide

Community Networking

- Encourage community participation
- Increase positive Social Roles
- It is a natural support all of us use
- They tend not to disappear after a few months
- Opportunity to develop friendships (unpaid)

AHCCCS Person-Centered Service Plan Pg. 16

Ask: **Why is community networking so Important?**
Take some responses

Click
Here are some more reasons:

- **Encourages more participation in the community**
  - **In line with the CMS Rules**
- **Increases Valued Social Roles**
- **We all depend on some support from our community**
- **They tend not to disappear, are long lasting**
- **Gives people the opportunity to develop reciprocal friendships**

Next slide

Ways to Enhance Community Networking

How do most people make friends?

- Work
- School
- Places of worship
- Through other friends
- Through a club or interest

What do all of these avenues have in common?

AHCCCS Person-Centered Service Plan Pg. 16

Ask: **How do we make friends and develop contacts?**
Discussion of how you develop contacts, make friends.
Click through the list.

Ask: **What do all of these avenues have in common?**
Possible responses:

- Places where you see the same people over and over again
- Meaningful interaction over and over

Next slide

Examples of Non-Paid Supports

A ride to work

Friend or family

A Neighbor's House

A home cooked meal

Co-Worker

Help with homework

Mentor

A place to go when nobody is home

Someone to help figure out a problem

Church member

Here are some common scenarios of when any person might need assistance. Who could you go to if you had this need? Click through the list asking the questions below and allowing people to respond. After each is answered with ideas, click again to see the possible answer on the slide

Click
A ride to work?
Take responses
Click
Maybe a co-worker?

Click
Help with homework?
Take responses
Click
Maybe a friend or someone in the family?

Click
A place to go when nobody is home?
Take responses
Click
A neighbor's house?

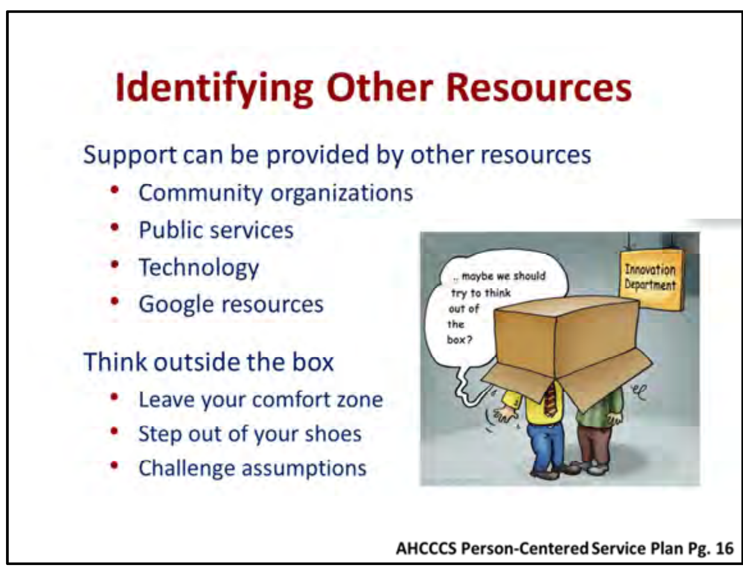
Click
A home cooked meal?
Take responses

Click
Someone from church?

Click
Someone to help figure out a problem?
Take responses
Click
Maybe a mentor?

As you can see, there are lots of people in someone's life who might be able to provide some type of unpaid support at some time. It could be a lot of people doing little things. It doesn't have to be the same people doing everything all the time.

Next slide



Ask questions below:
How do you find resources for yourselves?
Take several responses.

Does anyone have a smart phone? How often do look up local transportation? What do you find?
Take several responses.

How about housing?
Take several responses.

Click
Supports can be provided by a variety of other resources.
Here are some other ideas which may or may not be available depending on where the member lives.

The key is to think outside the box when you can't seem to find anything.

Next slide

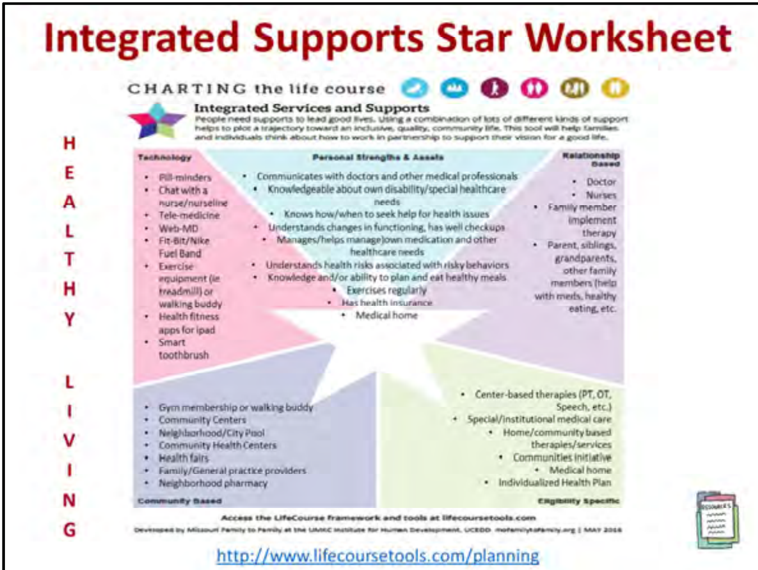
This "Integrated Supports Star Worksheet is from the "Charting the LifeCourse" tools that are available to download at the link on the slide. This can be very helpful when planning for integrated supports a person will need to achieve their good life. They also have a variety of "cheat sheets" to illustrate ways in which it can be used.

There are sheets for:

- **Daily Life & Employment**
- **Employment**
- **Respite**
- **Community Living**
- **Safety & Security**
- **Supported Decision-Making**
- **Healthy Living**
- **Social & Spirituality**
- **Citizenship & Advocacy**

You can find some of these in the "Examples" section of your booklet.

Next slide



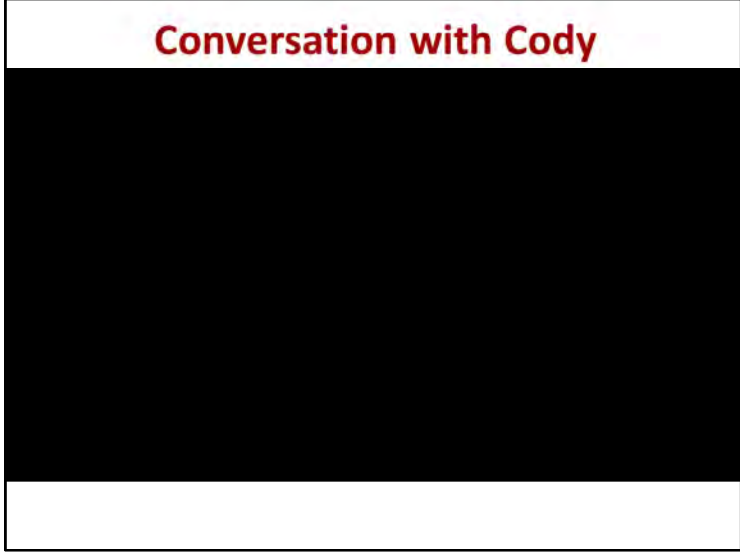
Here is one of the cheat sheets for Healthy Living.

The link to this resource is at the end of the PowerPoint.
I know the print is small, so I will read each section to you.
Review sections on the slide (also available as a handout in the participant workbook under Examples).

As you can see, they give a lot of good ideas that you might not have thought about.

The link to this website is listed at the end of the training.

Next slide



We’re going to watch a conversation with Cody, a young man who is 26 years old. He is a member of DDD and also receives BH services.
None of this interview was staged, it was a real conversation with him at his day program.
Any services and providers he mentions are not endorsed by us or AHCCCS, they just happen to be his current supports.
With Cody in the video was his mother and a staff member who works closely with him at the program.

Play video.
Ask:
What did you think about the interview?
What kind of conversation styles did you observe?
How does this conversation differ from how you currently talk with members about their goals?

Next slide

Identifying Resources

- What were Cody's expressed goals?
- What will he need to do to accomplish these?
  - Short range
  - Long range
- What other information do we need to know?
- What resources might be needed?
- How can he find the resources?
- Where can he get these resources?

Ask the questions on the slide (and below) as you go through the bullets and take responses for each:

Click
What were Cody's expressed goals?

Click
What will be need to accomplish these?
Short range and long range?

Click
What other information do we need to know?

Click
What resources might be needed?

Click
How can he find the resources?

Click
Where can he get these resources?

Next slide

Help people get better lives

Not just better plans…

The Learning Community For Person Centered Practices

Remember, Person-Centered Service Planning helps people get better lives, Not just better plans…

End of Goal Setting and Developing Outcomes Section.

This is a good time for lunch break.
After break:

Next slide

Risk
Identification
&
Assessment

AHCCCS Person-Centered Service Plan Pgs. 18-20

Assessing risks is a balancing between health and safety vs self-determination. We want to remember what we talked about earlier regarding the dignity of risk and allowing people opportunities to try new things. We've all made mistakes and we learned from them.

We are not looking at every risk, but the ones regarding health and safety that could interfere with the person doing what they want.

Next slide

Risk Identification Process

- Identify a risk
- Determine the following:
  - Is action needed to manage the risk?
  - Are more comprehensive assessments or referrals needed?
  - Is a Managed Risk Agreement needed?
  - Would an intervention to minimize or prevent risk restrict member rights?

AHCCCS Person-Centered Service Plan Pgs. 18-20

The risk assessment process consists of:

- **Identifying a risk**
- **Determining the following:**
  - **Is there any action needed to manage the risk?**
  - **Are more assessments or referrals needed?**
  - **Is a Managed Risk Agreement needed?**
  - **Would some intervention to minimize or prevent the risk restrict the member's rights?**

Next slide

What is a Risk?

- Anything that compromises the individual's general health condition and quality of life
- Having a specific diagnosis or condition, in and of itself, is not a risk
- Every individual must be assessed for risk

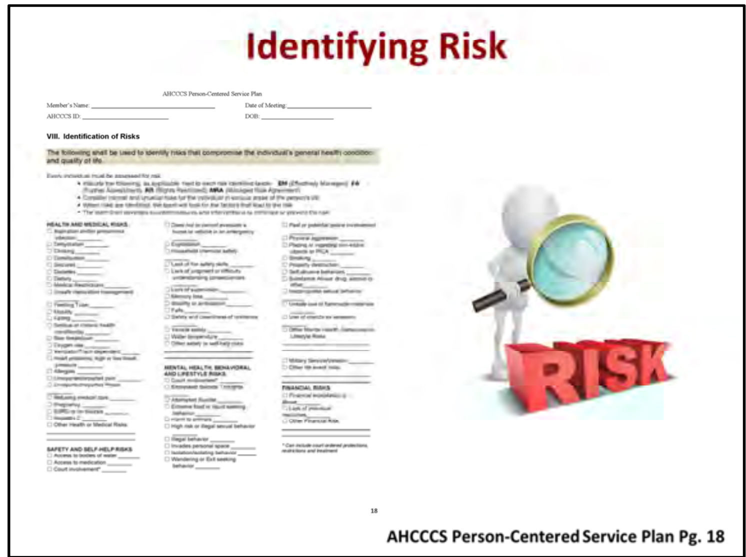
AHCCCS Person-Centered Service Plan Pgs. 18-20

A risk is anything that compromises the member's general health condition and quality of life.

A specific diagnosis or condition in and of itself, is not a risk.

Risks must be assessed for every individual.

Next slide



The risk assessment process starts with the tool on page 18. Use this to identify *all* risks.

Next slide

Identifying Risk

Identify all risks, but not everything needs risk assessment

- Consider normal and unusual risks for member in various areas of life
- When risks are identified, team will look for factors that lead to the risk
- For each identified risk, determine if action is needed and assign a code
  - Any risk could have more than one code
- Codes
  - **EM** – Effectively Managed
  - **FA** – Further Assessment
  - **RR** – Rights Restricted
  - **MRA** – Managed Risk Agreement
- If anything codes **RR**, complete assessment on next page

AHCCCS Person-Centered Service Plan Pg. 18

When using the tool, identify all risks, but not everything you identify will require you to do a risk assessment as defined by HCBS rules.

Consider the normal and unusual risks for the member in different areas of life.

The team will look for factors that lead to any identified risks.

For each risk, determine if an action is needed and assign a code. A risk could have more than one code.

If you look at the top section of the Risk Assessment you will see the codes to use:

EM – Effectively managed
FA – Further Assessment needed
RR – Rights restricted
MRA – Managed Risk Agreement

If any of the risks get an RR code, complete the assessment on the next two pages, 19 & 20, of the tool.

Next slide

Not every risk leads to a risk assessment

Risk Present/acknowledged/no action = no reduction in rights or independence (examples)

- Diabetes controlled with medication
- Member has had two heart attacks
- Member has barely enough resources to get by
- Member has an outstanding court order for non-payment of a debt
- Member uses a power wheelchair to get around
- Member has a hearing impairment

AHCCCS Person-Centered Service Plan Pg. 18

Every individual must be assessed for risk, but not every risk leads to a risk assessment.

Here are a few examples where there is a risk, but the is no restriction of rights or independence.
For example:

- **The member has had two heart attacks.**
- **The member doesn't have any resources.**
- **The member has a hearing impairment.**

Not every risk and health issue is a risk for purposes of HCBS and analysis of a risk or risk assessment. Just having a health diagnosis doesn't count.

For example, Johnny has diabetes and takes insulin. There are risk related to this – checking feet, blood sugar, etc. but you're not taking away his rights to independence or he can't go out because of the diabetes. So you don't have to do a full assessment.

Next slide

If Member's Rights are not Being Restricted

A risk assessment is not required, however

- Are supplemental assessments or referrals needed?
  - Behavioral Health
  - Medical (e.g. Skin Integrity)
- Is a Managed Risk Agreement needed as a result of:
  - Risks associated with the member or health care decision maker choices regarding services, placements, caregivers
  - Health and safety risks to the member, as well as risks to others as a result of the member's actions/behaviors/choices/decisions

AHCCCS Person-Centered Service Plan Pg. 18

If the member's rights are not being restricted then a full risk assessment is not required.

However, still determine:

- **Are supplemental assessments or referrals needed?**
- **Is a Managed Risk Agreement needed as a result of**
  - **Risk associated with choices regarding services, placements or caregivers?**
  - **Health & safety risk to member as well as risk to others as a result of the member's actions, behaviors, choices or decisions**

Next slide

Health and safety are important, but ALTCS members still have individual rights and independence – such as having a key to the door, privacy, access to fridge and food.

Just because they are ALTCS members doesn't mean they have to give up those rights afforded to everyone. If a risk requires that these type of rights be taken away, there needs to be a risk assessment.

Next slide

When is a risk assessment necessary?

- When **restricting** a member's right or freedom for health and safety reasons
- When not allowing a member to do something that people in the general population are allowed to do
- Family, providers or others may be restricting rights

AHCCCS Person-Centered Service Plan Pgs. 19-20

A full risk assessment is required when an intervention to minimize or prevent a risk for health and safety reasons would result in a restriction of a member's rights.

It may not be you restricting their rights or independence, others (family, providers) may be restricting rights.

Anywhere a member is living with other people (congregate setting), you can't limit/restrict rights of others in the home in response to one person's risk.

There may be times when rights may need to be restricted, but that doesn't mean forever.
You need to reassess every time to see if there are changes or new interventions to have the restriction removed.

Always explore if there are there things you can do short of taking someone's rights away.

Next slide

What are examples of restricting rights for health and safety?

- Not letting someone have keys to door
- Requiring the fridge and cabinets to be locked because of compulsive overeating

AHCCCS Person-Centered Service Plan Pgs. 19-20

Here are a couple of examples of restricting rights for health and safety.

- **Not letting the member have keys to the door**
- **Requiring that food be locked up because of compulsive overeating.**

Ask:

Do you have any examples of restricting rights for health and safety?

Take a few responses

Next slide

Risk

Risk Assessment

- When considering a restriction of members' rights or freedom for health and safety reasons.
- When not allowing member to do something that people generally are allowed to do.
- Review and analysis of how to minimize risk while allowing greatest freedom.

Managed Risk Agreement

- Document developed with member which outlines risks to member's safety and well-being as a result of choices or decisions made by member.
- Alternatives offered to the member and the member's choices with regard to placement and services must be documented.
- The managed risk agreement, signed by the member or health care decision maker must be kept in the member's case file

AHCCCS Person-Centered Service Plan Pgs. 19-20

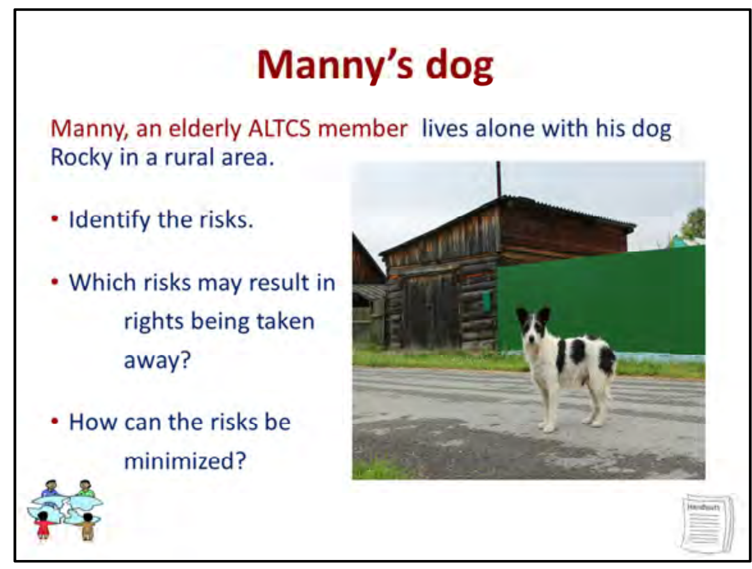
As always, all risks need to be identified during the service planning process. However, not every risk will need an assessment or intervention. This slide describes the difference between a risk requiring an assessment and risks that just need a managed risk agreement.

On the left, a risk assessment is required if an intervention is needed for health and safety reasons which results in restricting a member from doing something that people are generally allowed to do, such as have access to food in the fridge or cabinets.
Always review and analyze ways to minimize the risk to allow the most freedom possible. You should also be periodically reassessing whether or not the restriction can be minimized or lifted.

On the right, a managed risk agreement is needed if you have identified a risk as a result of choices by the member or health care decision maker, and the member does not want any of the alternatives offered to mitigate the risk. For example, the member left the stove on 5 times in the last week, forgot it was on and burned themselves. You can offer alternatives, but the member will still use the stove. An agreement is signed stating they acknowledge the risks.

Still use this as you do now.
Always explore if there are things you can do short of taking someone's rights away.

Next slide



We're going to do an activity based on this scenario. Manny's story is in your workbook under the Stories tab.

Read Manny's Story

Manny has lived in this house his entire life and his continued independence is very important to him. Most of the time, Rocky is Manny's only companion. His closest family, his daughter lives 100 mi. away. Rocky loves Manny but doesn't like anyone else. Rocky has nipped at ALTCS case managers/support coordinators, bitten home health workers, and growls at Manny's daughter. There are very few providers in the area and it's getting harder and harder to get anyone to provide in home services for Manny as Rocky's reputation is widespread. Manny uses a walker for mobility and is in the early stages of Alzheimer's. He often forgets to bathe or eat and the case manager/support coordinator has noticed that his house looks dirty with unwashed dishes and papers strewn about. His daughter is involved in his care, but she's busy with her family and job and can't come out to see him more than once a month. The closest small town to Manny's house is about 15 miles away.

In small groups:

- **First look at the Identification of Risks Tool in your Activities section and check all of the risks you have identified from the scenario**
- **Assign the appropriate code to each identified risk**
- **Determine if any of these actually poses a situation where Manny's rights may be restricted.**
- **What can be done to minimize the risks?**

You have 10 minutes then we'll come back together to talk about it.
When time is up:
What did you all come up with?
Guide the groups to report out answering the questions on the slide.

The correct answer is that Manny's rights do not have to be restricted, but a Managed Risk Agreement needs to be completed and signed.

Next slide

HCBS Regulation: Risk

AHCCCS Assessment and Service Plan

IX. Risk Assessment

WHAT IS THE RISK? DATE IDENTIFIED:

DESCRIBE THE RISK. WHAT DOES IT LOOK LIKE FOR THE MEMBER? FREQUENCY? LOCATION? DURATION?

LIST THE FACTORS CONTRIBUTING TO RISK

WHAT IS CURRENTLY WORKING TO PREVENT THE RISK (INTERVENTIONS THAT ARE WORKING AND NOT WORKING)?

WHAT IS THE RISK? DATE IDENTIFIED:

DESCRIBE THE RISK. WHAT DOES IT LOOK LIKE FOR THE MEMBER? FREQUENCY? LOCATION? DURATION?

LIST THE FACTORS CONTRIBUTING TO RISK

WHAT IS CURRENTLY WORKING TO PREVENT THE RISK?

- This page only needs to be completed for any identified risk where the member's rights will be restricted for health and safety reasons
- If there are more than 2 of these risks identified, you can add more to the bottom of the form

AHCCCS Person-Centered Service Plan Pg. 19

This is the first page of the form you fill out to review the potential risks. You can add more to the form if needed.

For folks who are having their rights taken away – CMS wants us to really know the cause of the behaviors/risk. List the factors contributing to the risk and what is currently being done to prevent the risk.

There are times that these restrictions may have to be in place. It may be appropriate because of the immediate risk, but it doesn't mean it has to be indefinitely. Always review to see if the restriction could be lessened or lifted.

Next slide

Analysis for Risks

- What are the causes/factors contributing to the risk?
- What are the least restrictive ways to mitigate risk?
- What is currently being done to minimize or prevent the risk?
  - Is it working?
- Are there things you can so short of taking someone's rights away?

AHCCCS Person-Centered Service Plan Pgs. 19-20

This outlines how you do the analysis:

- **Identify the causes/factors contributing to the risk**
- **Determine the least restrictive ways to mitigate the risk**
- **Explore what is currently being done to minimize or prevent the risk, and whether or not it is working**
- **Search for things that can be done short of taking away someone's rights**

The form is how you document if any action needs to be taken.

Next slide

Member's Rights are Being Restricted

- Must complete "Modifications to Plan through Restriction of Member's Rights"
- This is done with the team
  - Member & health care decision maker involved with development
- Ensure member's health & safety needs met with the least intrusive methods
- If rights are being restricted, that doesn't mean forever
  - Continue to find ways to mitigate, review and evaluate
- Continue to reassess to determine if restriction can be removed

AHCCCS Person-Centered Service Plan Pg. 20

After you've determined that a member rights will be restricted, you have to complete the "Modifications to plan through Restriction of Member's Rights" part of the risk assessment.

The development of the plan is done with the member and their health care decision maker if applicable.

Make sure the member's health and safety needs are being met with the least intrusive methods.

As I've said before, a rights restriction doesn't have to be forever. You should always be reassessing to determine if the restriction can be removed.

You could even help the member develop a goal around removing the rights restriction. You might use "Working/Not Working" to see if there are any changes that could be worked on.

Next slide

HCBS Regulation: Risk & Modifications

AHCCCS Assessment and Service Plan

Member's Name: ____________ Date of Meeting: ____________

AHCCCS ID: ____________ DOB: ____________

X. Modifications to Plan through Restriction of Member's Rights

This section is only applicable if a member's rights are being restricted. A member must provide informed consent prior to a necessary modification of conditions related to home and community-based settings being implemented, and providers cannot modify those conditions without such consent.

Describe the modification to the plan that is restricting the member's rights:

Identify the specific and individualized need that has been identified through the assessments of functionalized need (UAT, HCBS NEEDS TOOL, RISK ASSESSMENT TOOL):

Document the positive interventions and supports used prior to any modifications to the person-centered service plan:

Document less intrusive methods of meeting the need that have been tried but did not work:

Include a clear description of the condition that is directly proportionate to the specific assessed need:

Include a timeline for the regular collection and review of data to measure the ongoing effectiveness of the modification:

Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated:

Describe the assurance that the interventions and supports will cause no harm to the individual:

20

AHCCCS Person-Centered Service Plan Pg. 20

On this form you'll be describing the modification to the plan that is restricting the member's rights.

It is important to conduct this assessment around risk and completing the Modifications to Plan through Restriction of Member's Rights thoroughly and appropriately.

The member/health care decision maker is at the table and involved (to the extent they can and want to be) in the development of the modification plan.

We don't want providers to just *implement restrictions outside of the PCSP process.*

<u>The risk is not effectively managed until the member's rights have been restored.</u>

Ask

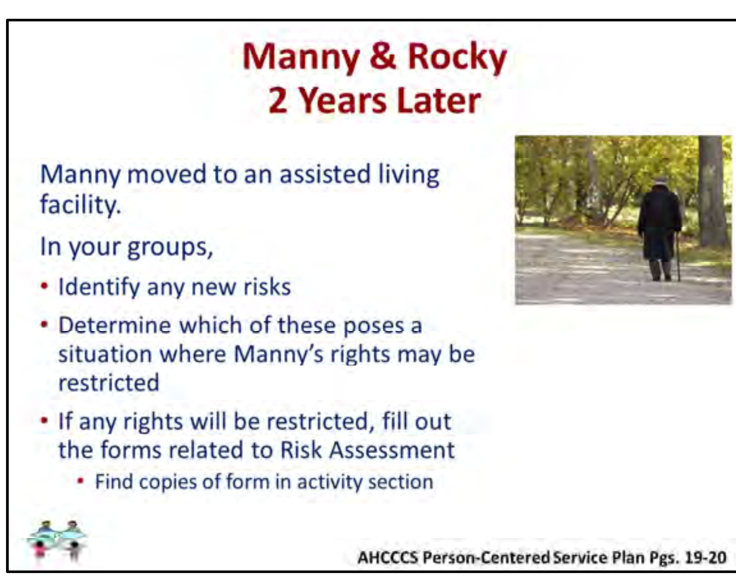
What do you do now for members who are unable to consent/make decisions, but don't have a health care decision maker?"

You are probably already having to make decisions in the best interest of the member.

If there is a situation where a member/health care decision maker refuses to consent to the plan, the SC/CM should document the refusal in the member's file.

If the team is unable to come up with an alternative plan that the member/health care decision maker agree to, but the restriction is absolutely necessary for the health/safety of the member, then the team would have no other choice than to proceed and document the team's decision and reason.

Next slide



Let's revisit Manny 2 years later. This in your workbook under the Stories tab.
Read scenario.

Manny continued to live alone with his dog, Rocky, until about 6 months ago. His dementia progressed, and he had several falls. His hoarding became worse and his living conditions greatly deteriorated. Manny was losing weight and he was unable to keep up with his personal hygiene. His daughter decided that he could no longer live alone, so she moved him to an assisted living home setting close to her home. The assisted living home does not allow pets, so Rocky could not move with him. However, Manny's daughter agreed to take Rocky in, and Manny goes to their home every other week for visits.

Manny loves his visits with Rocky but becomes very upset when he goes home and Rocky doesn't come with him. He walks around the home calling for Rocky and has been found wandering around the neighborhood looking for him. One day Manny left the home looking for Rocky, and he was found at a busy intersection trying to cross the street. Because of his wandering, the assisted living facility has moved Manny to a section of the facility that is locked at all times. Manny is no longer able to come and go as he pleases.

Have participants do this exercise with their same group.

In your groups:

- **Identify any new risks**
- **Determine which of these actually pose a situation where Manny's rights may be restricted**

If any rights may be restricted, work on the forms related to Risk Assessment in the Activities section of your workbook.
Complete the Risk and Modifications form.

Give 10-15 minutes for this.
When time's up, have the groups report out.
What did you find?
Be prepared to process with them and answer questions about their decisions.

After reporting out ask:
Are there any questions?

End of Risk Assessment Section.

This may be a good time for a break.
When back –

Next slide

Action planning is a crucial part of completing a PCSP.

Next slide

Goals Inform the Action Plan

The Action Plan should:

- Break outcomes into achievable steps
- Support balance of important to and important for
- Assign follow up by team members
  - Include agreed upon target dates for completion
- Include all items discussed requiring follow up
- Include natural supports

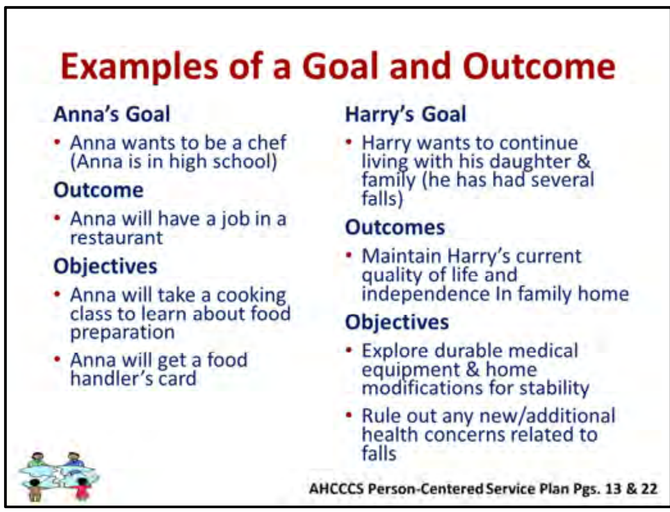
AHCCCS Person-Centered Service Plan Pg. 22

All we've been talking about leads to creating the action plan.

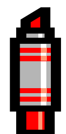
The Action Plan should:

- **Be reflective of the member's vision of the future and address what the member wants to do.**
- **Break outcomes into steps that are achievable.**
- **Support the balance of important to and important for.**
- **Assign action items to various team members with agreed upon target dates.**
- **Include natural supports.**

Next slide



Let's look at the goals, outcomes and objectives for Anna and Harry and how these might funnel into the Action Plan.



Use a flip chart paper to record responses. Make columns for:
Action to be taken Person Responsible Due Date

Fill in the responses to the following:
Here are just the first 3 columns on the Action Plan, but it will give you an idea on how to get started.

Anna's objectives could be assigned as action items.
Ask: **What might be some action items related to the objectives?**
Possible responses:

- Anna will look online to find cooking classes in her area of town.
- Anna's mother will help her get signed up for a class.
- Anna's friend will drive her to the cooking school.
- Anna will find out what she needs to do to get a food handler's card.

Ask about potential due dates for responses given.

Great! Now what about Harry's objectives?
Possible responses:

- Harry's case manager will refer him for medical evaluations.
- Harry's daughter will schedule appointments with his doctor.
- Harry will talk with his doctor about possible durable medical equipment (walker, cane, grab bars, railings).

Ask about potential due dates for responses given.

Next slide

Action Items For Follow Up

Some action items not related to goals and outcomes might be:

- Setting up an appointment for an assessment
- Following up on medical equipment
- Researching other residential options
- Making referrals for services

AHCCCS Person-Centered Service Plan Pg. 21

Action items may relate to other subjects or issues that came up during the course of the planning meeting and may not be directly related to a goal or outcome.

Some of these might be:

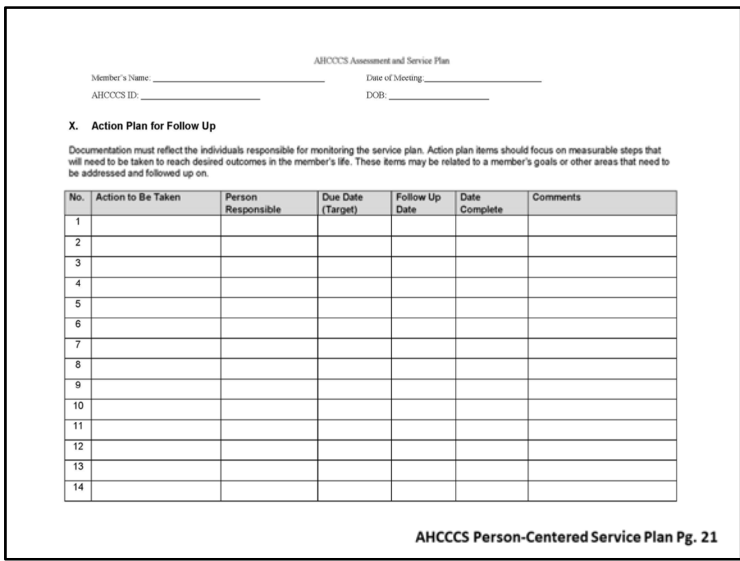
- **Calling to make an appointment for a needed assessment**
- **Checking on medical equipment**
- **Researching options related to discussion topics**
- **Making referrals for services**

Ask:

Can you think of anything else?

Take a few responses.

Next slide



AHCCCS Assessment and Service Plan

Member's Name: ______________________ Date of Meeting: ______________________

AHCCCS ID: ______________________ DOB: ______________________

X. Action Plan for Follow Up

Documentation must reflect the individuals responsible for monitoring the service plan. Action plan items should focus on measurable steps that will need to be taken to reach desired outcomes in the member's life. These items may be related to a member's goals or other areas that need to be addressed and followed up on.

No.	Action to Be Taken	Person Responsible	Due Date (Target)	Follow Up Date	Date Complete	Comments
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						

AHCCCS Person-Centered Service Plan Pg. 21

You will find the Action Plan on page 21 of the Person-Centered Service Plan. It should include all items that require follow up.

Next slide

Assigning Action Items

EVERYTHING discussed which requires follow up should be on the Action Plan

- Brainstorm with team about prioritizing action items
- Get commitments from team members
  - See what they are willing to do
- More than one team member might want to work together
- What are some strategies in assigning action items?

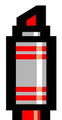
AHCCCS Person-Centered Service Plan Pg. 22

Everything discussed which requires follow up should be on the action plan!

Not only actions related to helping the member achieve the goals, but also items that have come up in the course of the meeting such as:

- **Making an appointment with a doctor**
- **Taking the member to a requested activity**
- **CM sending out copies of the plan**

It may take some brainstorming with the team to prioritize the action items. Get team members to commit to completing some of the action items.



Ask:
What are some strategies in assigning action items?
Record responses on flip chart paper

Remember, we came up with several ideas when we did the “Dealing with Various Situations” activity.

Next slide

Important To / Important For

- Must always be considered when developing action plan
- Balancing Important To & Important For is the key to a "Good Life"
- It's not about assuring safety & health at the cost of what creates satisfaction for the person

Important to/Important for must always be considered when developing an action plan.

Balancing the two is the key to a good life.

Remember, it's not about assuring safety and health at the cost of what creates satisfaction for the member.

Next slide

Review the Plan You Develop

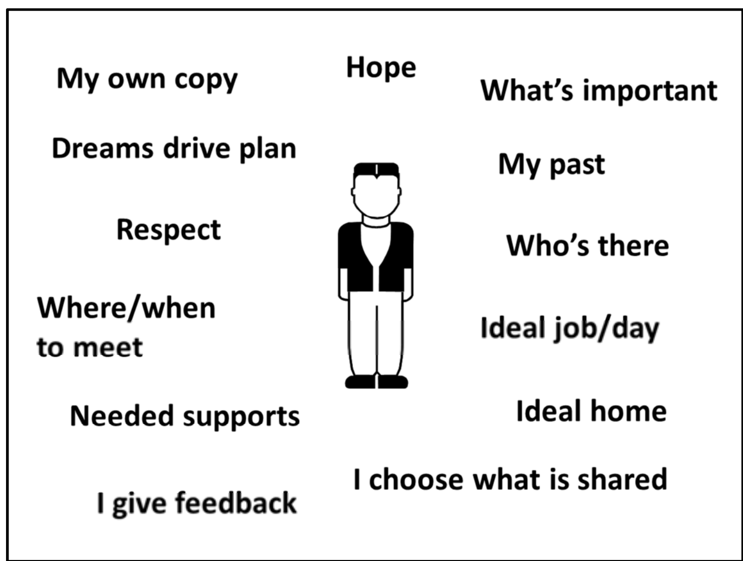
Remember - plans are how we introduce people

- Would reader meet the person before they meet the disability?
- Would those who use the plan know what you meant by what you wrote?
- Does plan capture the rich conversation that occurred in the meeting?
- Does plan meet the purpose?
- Have you described what still needs to be learned?
- Is it clear what needs to happen and who is responsible?

Keep in mind that the plans are how we introduce the members. Review the plan to see if these things are reflected:

- **Would reader meet the person before they meet the disability?**
- **Would the people who use the plan know what you meant by what you wrote?**
- **Does plan capture the rich conversation that occurred during the meeting?**
- **Does plan meet the purpose?**
- **Have you described what still needs to be learned?**
- **Is it clear what needs to happen and who is responsible?**

Next slide



Remember – it's about the member…it is their plan. The person is the center.

Next slide

Informed Consent & Sharing of the Plan

- The PCSP must be finalized and agreed to, *with the informed consent of the individual in writing*, and signed by all individuals and providers responsible for its implementation.
- If member or health care decision maker refuses to consent, document refusal in member's file
- The individual can decide with whom and what parts of the service plan can be shared.

AHCCCS Person-Centered Service Plan Pgs. 22-23

The PCSP must be finalized and agreed to*, with the informed consent of the individual in writing,* and signed by all individuals and providers responsible for its implementation.

If member or health care decision maker refuses to sign the consent, be sure to document refusal in member's file.

The individual decides what parts of the plan will be shared and who it will be shared with.

Next slide

Informed Consent

XI. Informed Consent

MEMBER / HEALTH CARE DECISION MAKER'S SIGNATURE	DATE
INDIVIDUAL REPRESENTATIVE'S SIGNATURE (Agency with Choice only)	DATE
CASE MANAGER / SUPPORT COORDINATOR'S SIGNATURE	DATE

Other Attendees Responsible for Plan Implementation:

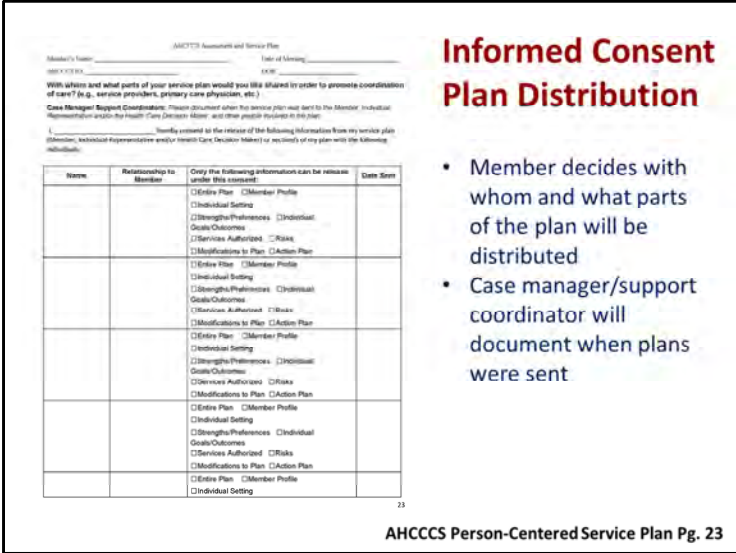
NAME	SIGNATURE	NAME OF AGENCY/RELATIONSHIP	DATE
NAME	SIGNATURE	NAME OF AGENCY/RELATIONSHIP	DATE
NAME	SIGNATURE	NAME OF AGENCY/RELATIONSHIP	DATE
NAME	SIGNATURE	NAME OF AGENCY/RELATIONSHIP	DATE

- Must be signed by member/health care decision maker and those responsible for implementation

AHCCCS Person-Centered Service Plan Pgs. 22

This is the first part of the Informed Consent on page 22.

Next slide

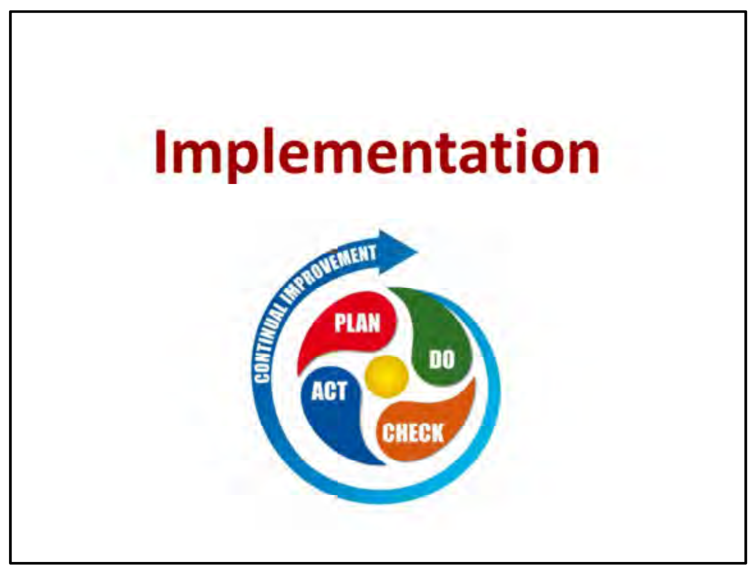


Use this page to document with whom and what parts of the plan will be shared.

This is also the page to document when they were sent.

End of Action Planning section.

Next slide



After the plan is completed, implementation begins.

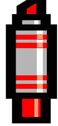
Next slide

Follow Up

How do you:

- Remind team members of assigned action items?
- Make sure they are following through with action items?
- Ensure they will be prepared to discuss progress at next meeting?

AHCCCS Person-Centered Service Plan Pg. 22



ACTIVITY

Read each question, one at a time, and ask the group to brainstorm on strategies.
Write down the ideas on flip chart paper.

Follow up begins after the plan is completed and distributed. How do you:
Click

Remind team members of assigned action items?
Possible responses

- Send out copies of plans and remind about action items
- Send emails following the meeting with assigned action items

Click
Make sure they are following through with action items?
Possible response

- Setting reminders to contact to track progress

Click
Ensure they will be prepared to discuss progress at next meeting?
Possible response

- Sending action items prior to next meeting and reminding team members that they will need to report progress made.

Next slide

Always start meetings talking about:

- **Progress on action items**
- **Newly identified barriers**
- **Brainstorming solutions**

Be sure to celebrate the successes!

Next slide

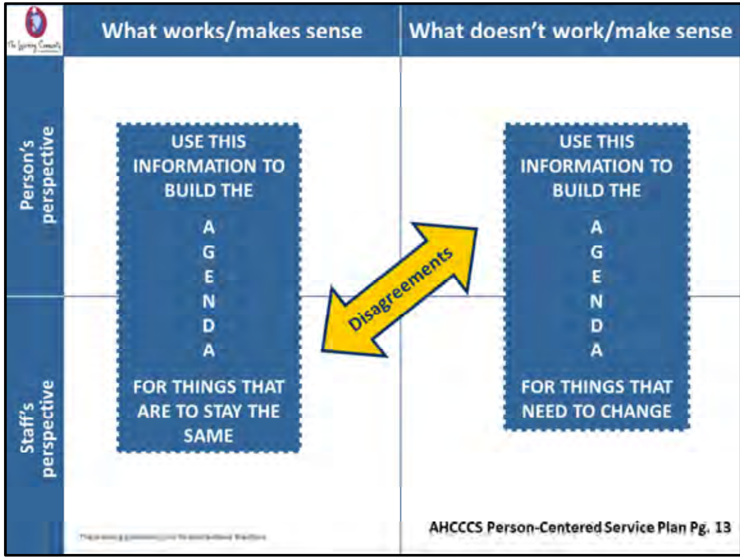
After you've completed the first Person-Centered Service Plan, the following meetings will be used to assess progress and how to move forward.

Two discovery tools that are helpful are:

- **Working/Not Working**
  Which we've talked a lot about today

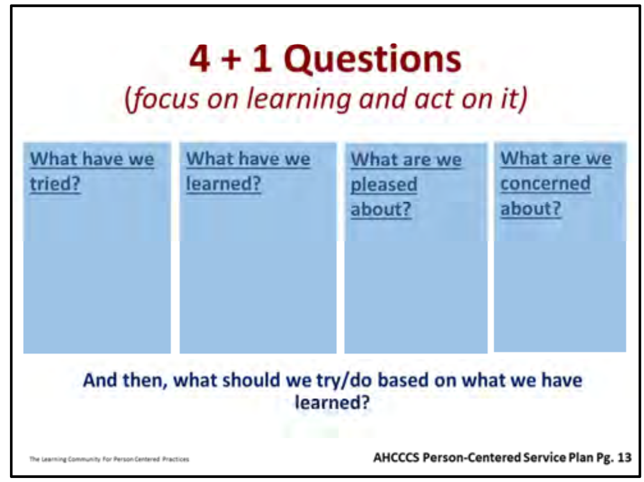
- **4+1 Questions**
  This tool helps to evaluate what's been accomplished so far

Next slide



Remember how we talked about using this tool to develop action items? It can be used again to assess what needs to stay the same or be enhanced, and what needs to change as the plan is implemented over time. Use it the same way we did in our activities.

Next slide



The 4 + 1 questions help to clarify what's happened and what needs to happen next.
The questions are:

- **What have we tried?**
- **What have we learned?**
- **What are we pleased about?**
- **What are we concerned about?**

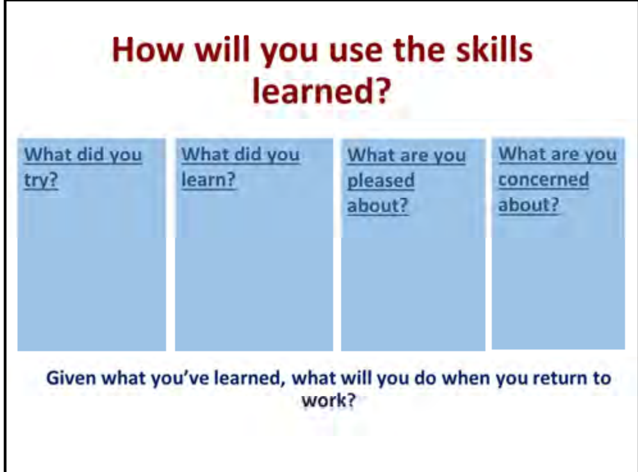
You can do this through discussion with the team or you can place the questions on flip chart paper on the wall and let everyone write their responses.

Possible Tip
Ask:
Have you ever have long meetings where there is lots of talk and not enough action or where the same things are discussed over and over again with no action or progress?
This may be a helpful tool to avoid that.

The 4 questions are posted on the wall at the beginning of meetings with everyone writing their responses to the questions before the meeting starts. This ensures that learning is captured quickly and the problem of having some learning drowned out by a "dominant voice" is avoided.

This is a more productive way to manage time that is more efficient in working through issues or coming to solutions.

Next slide



This is the last sheet in the Activity tab in your workbook. Take a minute to fill out the 4 + 1 questions for yourselves based on the skills you've learned during this training.
Please answer:

- **What did you try?**
- **What did you learn?**
- **What are you pleased about?**
- **What are you concerned about?**

When people seem to be done:
Anyone want to share or reflect on use of the tool?
Take responses

End of Implementation section.

Next slide

PCSP is a set of promises

A Promise to listen

- to listen to what is being said and to what is meant by what is being said
- to keep listening

A Promise to act on what we hear

- to always find something that we can do today or tomorrow
- to keep acting on what we hear

The Learning Community For Person Centered Practices

Person Centered Service Planning is a set of promises.

A promise to listen to what's being said and what is meant, and to keep listening.

A promise to act on what we hear. We can always find something that we can do right away and keep acting on what we're told.

Next slide

PCSP is a set of promises

A Promise to be honest

- to let people know when what they are telling us will take time
- when we do not know how to help them get what they are asking for
- when what the person is telling us is in conflict with staying healthy or safe and we can't find a good balance between important to and important for

The Learning Community For Person Centered Practices

It's also a promise to be honest.

Honesty is a part of trust. Honesty is required to maintain trust. If trust has been broken honesty is a critical requirement in regaining trust.

Some things take time – you may be able to help someone achieve their goals but not overnight.

But don't use honesty as an excuse – don't forget to really listen.
When we can't figure out how to help the person get what they are asking for, what can we do?
What is underneath what they are asking for?
How close can we come?

Next slide

It is more than planning

Person-centered service planning – by itself
Results in Better paper
More often than it results in Better Lives

The purpose of PCSP is
LEARNING THROUGH SHARED ACTION

PCSP calls for a sustained search for ways to deal with
difficult barriers and conflicting demands

IMPLEMENTATION IS KEY

The Learning Community For Person Centered Practices

Person Centered Service Planning is more than planning.
It doesn't just result in better paper. It results in a better lives.

The purpose is learning through shared action.
Identifying the goals and *the team working together to make it happen.*

It requires an ongoing search for ways to deal with the barriers the person may face.

Implementation is critical! A PCSP must be acted upon and realized.

Next slide

Let's take a look to see if there are any unanswered questions. Does anyone want to move their question before we do this?

Read each remaining question. If it's something that has already been discussed, give a *very brief* answer reflecting what was taught.

If there are any questions that weren't answered, try to answer them or explain where they might find that information.

Thank you!

Next slide

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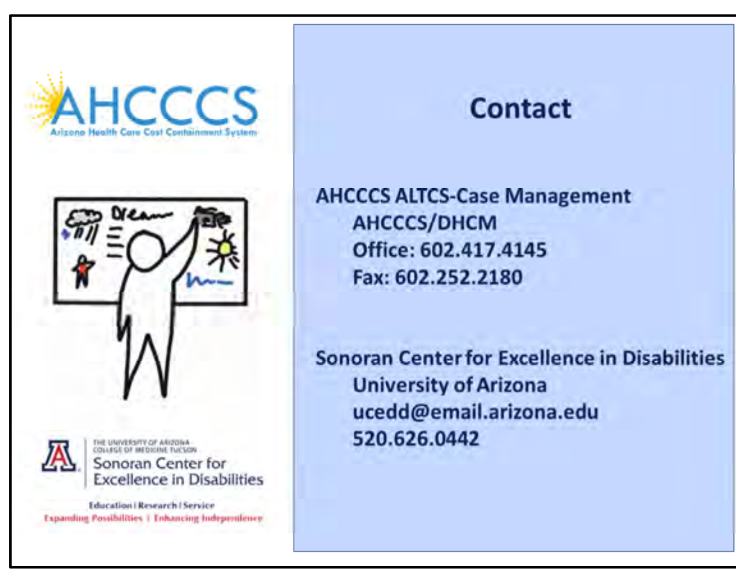
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