Massachusetts Building Blocks for Person Centered Planning

Facilitator's Manual to the My Person-Centered Plan

April 26, 2010

How the Person-Centered Plan Framework and Facilitators Manual Were Developed

This Person-Center Plan framework and Facilitators Manual were developed by Advocates, Inc.; Baypath Elder Services; Self-Advocates supported by Advocates, Inc; Department of Mental Health deaf case managers; Department of Developmental Services training department; Deaf Service Coordinator, Department of Developmental Services; the Executive Office of Health and Human Services; Executive Office on Elder Affairs, and, with input from many others including those from Mass Commission for the Blind, Mass Rehab Commission and Mass Commission for the Deaf and Hard of Hearing. The person-centered planning framework was developed to aid facilitators in the development of Person-Centered Plans that work towards Self Direction and improve one's quality of life. This manual is to assist facilitators to better understand Person-Centered Planning and their role in supporting elders and persons with disabilities in directing their planning process to identify and achieve their hopes and dreams.

The guide to Person-Centered Planning is the document that can help a facilitator in using the Person-Centered Plan framework. Person-Centered Planning and Self-

Determination are closely linked. The process of Person-Centered Planning promotes a thorough exploration of the person's interests. This equips the person and his/her planning team with important information from which he/she can direct resources. The Person-Centered Plan helps to prioritize the use of resources according to what is most important to the person.

It was developed to help persons customize their Person-Centered Plans. The pictures in the framework can be changed to pictures that are meaningful to the person. Many persons choose a colorful or styled binder or a personally decorated binder for keeping his or her plan.

Using the Person-Centered Planning Framework

The Facilitator's Manual should be used to assist the facilitator through the process of developing a Person-Centered Plan using the Person-Centered Plan framework. The framework does not have to be completed in any particular order or in its entirety. Depending upon the person's wishes, the information can be obtained by the facilitator formally at the Person-Centered Planning meetings or informally outside of the meetings. The information will be gathered over time throughout individual and team meetings. Plans should be completed at the person's pace and facilitators should not feel rushed or compelled to complete the entire packet.

The following pages contain helpful hints and suggestions to assist the facilitator in completing the Person-Centered Planning Framework.

Self-Determination

Self-Determination -"Determination of One's Own Fate or Course of Action"

American Heritage Dictionary

Self-determination is a principle that places decisive power about the design of a person's life in their own hands. Service delivery systems that embrace self-determination put the person in the primary decision making role regarding the design of services and the use of funding to support their needs. In self-determination, the person, not the service system, takes charge and responsibility for their life. The person decides where he or she will live, and with whom; what type of services he or she requires, and who will provide them; how he or she will spend his or her time, and how he or she will relate to the community and developing and maintaining relationships with others in the community.

Person- Centered Planning is a framework for planning and making decisions and is based on an awareness of and sensitivity to the person's lifestyle and cultural background. This process recognizes the person as the expert on his or her life, with every decision, suggestion, and resource determined by what he/she identifies as what he/she wants and needs.

Important Components of the Principle of Self-Determination

Freedom to choose a meaningful life in the community

Authority over a targeted amount of dollars

Support to organize resources in ways that are life enhancing and meaningful to the person with a disability

Responsibility for the wise use of public dollars and recognition of the contribution persons with disabilities can make to their communities

Leadership role of persons in a system that supports self-advocacy

Self Direction

Self- Direction is the process – not a program or a model - by which persons exercise the philosophy of Self Determination by giving the person the responsibility, authority and freedom to design and control their services and supports.

Self-direction may appear to be a very simple concept; but, it can be a challenging process to implement. From the person's perspective, self-direction in a service system must allow the person to:

- Have more say about their life

- Have people listen to them and what their needs are
- Learn by acting on their choices
- Be able to do something when they are frustrated
- Make changes in their life when they want to

Self-direction in service systems include one or more of the components listed below:

- Self-Advocacy Training
- Person-Centered Planning Process
- Circles of Support
- Support Brokers
- Person Budgets/Control Over Money
- Financial Management Services
- Budget Authority/Employer Authority
- Risk Taking/Attitude Shift

Overview of Person-Centered Planning

Person-centered planning is a process, directed by the participant, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the participant.

The Centers of Medicare and Medicaid (CMS)

The person-centered planning process is centered on the person and not on the state, the provider, or the family. It supports the growing movement across the country to change from a system driven service planning to a person-directed process where the individual identifies what is important to him or her and, through the process, expands the circle of supports to assist the individual to achieve his or her goals while maintaining safeguards.

It is a comprehensive strategy for putting necessary services and supports in place to help people achieve their goals. Person-centered planning is driven by the individual, but works best when it includes other people (both paid and unpaid) who can contribute valuable information to the process.

The Minnesota Governor's Council on Developmental Disabilities publication book "It's My Choice..." defines person-centered planning as "one way to figuring out

where someone is going (life goals) and what kinds of support they need to get there." It is about supporting people in the choices they make about their life.

Person-Centered-Planning is a process of listening and learning from elders and individuals with disabilities about their lives and the goals and dreams that they would like to achieve. Many individuals have life goals and dreams they want to accomplish, or they may desire change in their living environments, employment, day activities, or who they spend time with. Throughout the planning process it is most important to keep the individual at the center of the planning process. Paid staff, friends, relatives, and others are there to support them to make decisions about their own life.

The key elements of person-centered planning include:

- Is driven by the person and his/her preferences
- Establishes a vision based on strengths, capacities and preferences
- Based on informal and formal knowledge and supports
- Requires collaborative teamwork
- Requires a commitment to action
- Process uses a facilitator

Person-centered planning begins with a clear and shared appreciation of the gifts and capacities of the person. It

involves committed people develop a common understanding the person's dream and meet regularly to brainstorm and act on commitments

What is a Facilitator?

The "facilitator" is someone who is trained in, and committed to, the principles and practices of person-centered. Put simply, the facilitator is the one who helps to make the person-centered process happen and, by supporting the focus person (the individual for whom the plan is happening) ensures it is successful. The facilitator ensures that the values and steps of the process are delivered in a manner that is consistent with the principles of person-centered planning. The primary role of the facilitator is to support the focus person in expressing his or her aspirations, hopes, dreams, and preferences and to ensure that these remain at the heart of the planning process throughout. The focus person should be encouraged to control the process to the greatest degree possible, e.g., having him or her start the meeting and lead the introductions can make a significant difference in setting the tone for initial and ongoing meetings.

What are the essential skills of the facilitator?

The following list notes the essential skills for a Person-Centered Planning facilitator:

Listening skills:

- Listen to what people are "saying"
- Assist meeting participants to listen to each other

- Listen below the surface to what is not being said

Visioning skills:

- Think, and assist others to think, beyond the formal service system to include a network of natural supports
- Able to assist the focus person and the participants to dream big!
- Able to suggest large and small dreams, goals, and objectives
- Able to work with the team to tap into community supports and activities
- Able to solicit information from participants such as how to access culturally appropriate services
- Able to encourage the focus person to use gifts and skills to further his/her own recovery *and* to give back to team members or the community as a whole

Communication:

- Able to use and to teach others to use "people first language"
- Able to define and discuss all aspects of person-centered planning
- Able to use common language in place of professional jargon

Meeting Process:

- Able to assist participants to adhere to person-centered planning principles throughout the meeting
- Able to encourage the focus person to be an active participant in the meeting and in the action steps of the plan itself
- Able to solicit all viewpoints and to make sure everyone has an opportunity to provide input and be heard
- Able to build consensus among participants
- Able to deal with challenging participants, and to use conflict management skills to deal with conflict
- Able to engage participants and re-convene the group over time as necessary

Circles of Support

A Circle of Support is a group of people who care about a person and have a personal (and sometimes professional) commitment to him/her. To determine a Circle of Support, it is imperative that you first ask the person who he or she considers to be supportive. Be sure to not make assumptions – just because a person has an active role in the life of the person who is receiving services, that does not automatically mean they should be included.

Creating a Circle of Support is a key element to creating a successful Person-Centered Plan. Many persons may not have a full Circle of Support when the process begins. Facilitators should work creatively to develop action plans that would increase the number of people that can be helpful to the person in supporting his/her plan. Most people thrive through connection with others therefore the facilitator should encourage relationship building and creating a social network.

Facilitators should use the guide in the framework's page 6 to aid in filling in the Circles of Support graph on page 8. For persons who prefer visual plans, this is a great opportunity to add pictures of group members. When completing the graph place those people closest to the person in the inner circles and keep in mind that the Circle of Support will and should change as relationships

change. For example, a hairdresser may become a friend over time and would move from Circle Three to Circle One or Two. A paid staff person may be very close and dear to a person and could be included in Circle One or Two.

People in the Circle of Support will meet regularly to celebrate successes and/or discuss changes to the plan. When the Circle of Support meets it is an opportunity to introduce the person to other people who could assist with achieving goals. For example, if a person wants to become an auto mechanic and someone in the Circle of Support has a friend who owns a car repair shop. After receiving permission from the person, perhaps the shop owner is invited to meet him/her to offer an opportunity or to give information on the best way to become an auto mechanic.

One of the outcomes of person-centered planning can be a circle of people who are interested in making a positive difference for and with a particular person. Around each person are people who live, work, or spend leisure time with that person. The circle of friends provides a very important support network for the person. The group meets regularly with the person to celebrate successes and discuss challenges and brainstorm solutions. When a naturally formed circle of friends is non-existent, direct support professionals can facilitate the development of a circle.

Since birth, we have been creating an intricate network of people in our lives; friends and/or family who are there for us in times of trouble, sorrow, and celebration. Those friends take an interest in us and our lives because we share common threads that bind us to one another. This group is called our Circle of Support or Friends. They are people we value in our lives who help us achieve our dreams or lend a hand when we are in need. We can count on them to be there for us. These relationships are formed in many ways, but generally come from meeting people in different places and environments. Meeting people, for most of us, occur naturally and for the entirety of our lives.

Judith Snow, a woman with a significant disability, explains it further and described below four different circles of relationships that everyone has in their lives. We have added Circles five and six following suggestions from people involved in directing their planning.

Circle One: The **Circle of Intimacy** is made up of those with whom we share great intimacy, our secrets, and heartfelt emotions. These are people or perhaps animals or objects that are so dear to us that their absence would impact us greatly. This may or may not include family members.

Circle Two: The **Circle of Friendship** is made up of those people who are friends or relatives whom we call upon to go out to dinner, see a movie, but are not those whom we consider our most dear friends or those we must see regularly.

Circle Three: The **Circle of Participation** is where you belong and includes the names of the people or organizations you participate with in life. This could contain spiritual groups, where you work, where you went or go to school, clubs, organizations, athletic teams, or where you participate and interact with people. Some of these persons may later be in Circle one or two! Circle Three is the garden for sowing future relationships.

Circle Four: The **Circle of Exchange** is made up of people who are paid to be in our lives. Doctors, teachers, dentists, social workers, therapists, hairdressers, car mechanics, and the like make up the numbers here.

Circle Five: The **Circle of Mentoring** is made up of people whom you consider to be mentors. This may be a professional mentor, spiritual mentor, or any other mentor in your life.

Circle Six: **Re-connecting with people from your past**. This is an opportunity for you to identify people whom you were close to in the past that you might want to re-connect with.

Snow explains that when we look at the circles for people without disabilities, we can see that there is a fair number in each circle. However, if we were to look at the circles for elders or people with disabilities we often see a very different pattern.

For the person, there may be people in Circle One and Circle Four. Actually, in many instances, Circle Four explodes with people paid to be in their lives. Circle Three, the key circle, has minimal organizations or social opportunities available for them and thus, persons with disabilities are excluded from creating connections to others and developing a true circle of friends or support.

While most of us have an easy and natural time creating relationships and circles of support, seniors and people with disabilities struggle with this aspect of their lives. That is why helping them create a circle of support/friends can be a way to support their ability to develop meaningful relationships.

The person should be present at and participate in every circle; after all it is their life the circle is discussing. When the person cannot do this and someone else needs to act as their proxy, it is vital that the person is someone who is trusted and knows the person well. Other core principles of Circle of Support include:

- The PERSON as decision-maker
- Roles and expectations of circle members

- People who care about the person
- Balancing the Circle
- Key to safeguards
- Concept does not belong to any one person
- A group of people who agree to meet on a regular basis to help the person attain their hopes and dreams
- Paid people, non-paid people

There is no one way. Some persons—because of personality, verbal skills, vulnerability, the efforts of others (e.g., parents), or for yet other reasons—have larger numbers than others of close family members and friends constructively involved in their lives. Circles of support are meant to gather a supportive community around the person with a developmental disability.

The circle of support seeks to develop community connections, to invent and experiment with novel courses of action, and to stand by the person as any close friend would do. The essence of person-centered planning is having the person with a disability (along with family and friends) create a vision of a desired future, identify the support needed to get there, and determine what steps to take, here and now, in pursuit of that desired future.

Some Circles of widely varying sizes and degrees of organization are put together by the person, family, or friends, simply because of shared interests, mutual

commitments and caring, and the joy of being aligned with each other.

Team Meetings

Now that you have begun creating and graphing the Circles of Support, you will discuss with the person whom he/she would like to attend his/her initial team meetings. Document this on page 9. Not everyone who is part of the team needs to attend all meetings. Instead, the facilitator and the person should determine attendance based upon the member's contribution to the plan as well as that particular meeting's agenda. The team meeting is also a time for the person to hold members accountable for following through with what they said they would do.

THE FIRST MEETING WITH THE PERSON AND THE TEAM

As you went through the Circle of Support exercise, with the person, you may have noticed that there were some questions that were easier than others for them to answer. Now is the time to follow up on some of the questions and people that seemed to be of interest the person.

You can finalize with the person about who is important to them and identify with them, whom they would like to have at their initial team meeting. If it is important to him/her for someone to attend this meeting then, of

course, they will be invited; however, not everyone of the person's team needs to attend. If there is a specific contribution to the plan or agenda item that someone needs to be there for they should be invited.

As you prepare for the meeting it is important to be clear about the meeting's purpose. One of the critical purposes of the meeting is to develop a shared understanding of what this person wants and needs in their life. Also understand that this is NOT IT.....this plan needs to be a living document. When things change in the person's life the plan needs to be revisited to accommodate those changes.....it involves consistently listening to the person over time and including that ongoing learning in the plan.

The facilitator has a key role in ensuring that the plan consistently demonstrates a deep respect for the person's dignity and focuses on quality of life rather than needs that might emerge from the system. They must be able to organize the meeting in a skillful way and make sure they stay non-judgmental and curious about the various points of view that will surface. Remember:

"The success of an intervention depends on the interior condition of the intervener." William O'Brien, Former CEO Hanover Ins.

Each meeting will be different and may be a place for potential conflict. When people get together who care deeply about something emotion and passion often surface. Consider that the people at the meeting are the right people, are there because they care about the person and they come with their highest intentions of good will for the person.

These are some guidelines to consider while you prepare for and participate in the meeting:

BEFORE THE MEETING

- ☼ Make sure everyone, who needs to, has had input into how the meeting will be run
- ☼ Make sure everyone is clear about the purpose of the meeting (a PCP meeting), why they have been invited to attend and who will be there
- ☼ Make sure all the people the person has invited are able to attend and if they are not able to that the person has been informed of this
- ☼ Confirm that the meeting space is welcoming, is conducive to conversation and supports creativity
- ☼ Check in with the person to be sure they know this is a person centered process and will ask for what they want.
- ☼ Determine if you will be using guidelines during the meeting such as – speak freely, no jargon,

DURING THE MEETING

- ☼ Make sure everyone is comfortably seated and the person can see everyone
- ☼ Make certain that the person remains 'in the center' of the conversation. If things stray into organizational or other people's needs bring them back to why they are there and who the process is for.
- ☼ Make sure that everyone who wishes to speak has an opportunity to do so. A talking piece can be used to ensure that the person holding the piece is the only one speaking.
- ☼ Make sure you help the person to have a voice during the meeting and that the pace is conducive to hearing all that is said
- ☼ Invite people to speak with intention and listen with attention.
- ☼ Make sure that people have made the time for the meeting and have turned cell phones and other electronics off.
- ☼ If something is not working or the conversation is beginning to be an endless loop holding up the meeting, consider tabling it for the time being. Move on with the acknowledgement that you will return to the discussion later. Tabling often provides an opportunity for people to return later with a fresh perspective.

AFTER THE MEETING

- ☼ Thank participants for attending.
- ☼ Discuss with the person how the plan will be made available to them before others see it.
- ☼ Determine if and how the information and decisions generated during the meeting will be shared with participants. If alternative ways of recording have been used (i.e. tape recordings, graphic recordings) consider those as well.
- ☼ Set a date, time and place for any subsequent meeting that might occur.
- ☼ Make sure you do what you say you will do.

When developing a plan we are entering into a process that can create personalized possibilities for the person. We enter into an implicit agreement with them that says we are going to help them have the things, people and opportunities they want in their lives. To fall short of that outcome leaves the person with little trust that such a process will work.

Planning like life evolves over time and is a living, iterative, learning process. You can never plan just once with someone...continuous check in with the person and modification of the plan is necessary to enable someone to live the life they want.

Caregiver Assessment

The Caregiver Assessment section was developed to capture times in a person's life when they are receiving informal supports from someone. This may be a family member or friends who are not paid, but do assist with care giving activities, such a banking, cooking or personal care, etc.

Caregivers are often in need of support themselves. The facilitator may create action plans to address bringing in additional supports to the person that provide a break to the caregiver or bring supports that the caregiver might need (such as a caregiver support group). Without being sensitive to the caregiver's needs, they may no longer be able to provide the supports to their son, daughter, or friend.

The Person-Centered Planning Framework includes a series of questions to be completed for the person directing their planning process about, if relevant, their caregiver(s). In addition, there is a series of questions to be completed by the facilitator with the caregiver(s) to conduct an initial screening of the caregiver(s). This is to assist the facilitator (and the team) in determining what the caregiver's needs are. If needed, an action plan to support the caregiver, could be incorporated within the person-centered plan.

If through the initial screening it is determined that more focus on the caregiver is needed, there are more in-depth caregiver assessment tools that are available to the facilitator. For facilitators working with elders, a determination would be made if a referral to the Family Caregiver Program through the local Aging Services Access Point (ASAP) Family Caregiver Program.

My Thoughts, About Me, What Works and Doesn't Work

This section of the toolkit (pages 11-14) is the place for the person to think about who he or she is. Completing this section is a time for the person to think about what is important to them, what's been meaningful in his/her life, what are his/her successes and what is it that makes him/her feel proud. It helps the person focus on thinking about who they are, what changes they may want to make about their present situation and what they want to see happens in the future. Focus on the positive and strengths without minimizing the negatives and weaknesses. Encourage the person to be honest and truthful with their thoughts and feelings.

Some examples may be:
What are you good at, at home or work?
What do you like to do?
Are there places you like to go?
What do other people say you are good at?

The goal is to help them decide and record what works well in his/her life and what doesn't work. The facilitator will learn a great deal about the iperson during this part of the Person-Centered Planning process and should take

the time to listen to the individual in order to build a shared appreciation and understanding for who he/she is.

Depending on the person's wishes the facilitator can meet with them alone to start gathering this information or, if the person prefers, he/she may want others (e.g. members of the individual's circles of support) to participate in the "Getting to know you" process. If the person chooses to have others participate it is very important to write down whose opinions or thoughts that you are recording.

Facilitators should be creative and thoughtful in how they ask questions and how to listen openly. If needed, alternate means of communication such as pictures can be used. For some; pictures can help individuals to remember and think about their experiences more than just writing down words. Use probing and open-ended questions instead of yes/no questions that help the individual think in greater details, and as much as possible, ask them to describe the mental images that they are seeing of themselves as they talk. Use humor to engage the individual so that he/she would find the exercise fun.

As the facilitator, you must spend time documenting Quality Factors and Values to Uphold. Every person has his/her own beliefs, values, traditions and practices. If these are not documented for the person, the facilitator

and the circles of support could mistakenly be working against core values held by the person. As the facilitator, you explain this part as "the must haves" in their life. These are the things they cannot live without and they are not willing to give up. Examples of "must haves" might be membership at a specific house of worship or only living in a setting that allows a therapy pet. The "must haves" can be temporary or long-term depending on the person's life circumstance and needs at the time. It should be reviewed periodically to ensure that it is current and applicable.

In identifying what the person must have, what must not change, he/she will discover what is missing and will include the item in their Goals and Dreams to be achieved. In reviewing their cultural beliefs and traditions, they provide a context for the individual's goals and dreams; for example, religious practices such as observing Lent or Hanukah may lead to discussions about their other habits.

Goals and Dreams

Pages 15 and 16 will initiate discussions about future goals and dreams. Encourage the person to describe in detail what he/she sees their life will be tomorrow, 6 months or 3 years. Have him/her describe different aspects of their life such as whom they will want to be their friends, where and how they will be living, what they will want to be doing, what they think will make them happy. Once goals and dreams are identified you will walk the person through creating an Action Step.

Developing Action Steps

Once goals are identified pages 17-20 will guide facilitators through creating action plans to achieve these goals. Many people may identify more than one goal. Be sure to use separate "Action Plan" sheet per goal. Many persons have the experience of people in his/ her life not following through on action steps. It's vital for accountability to record who is responsible for accomplishing what along with a timeline for when it will be accomplished. The person, facilitator, and team should all hold each other accountable for their agreed participation. Action Steps should be broken down into

smaller goals that over time will accomplish the overall goal.

The "Things I Want Done Now" sheet is an optional sheet that can be used in a variety of ways. Some people may choose to use this sheet to record small goals that can be accomplished immediately such as, a person opening a bank account. The sheet can also be used to record all action steps that have been accomplished.

The "Community Inclusion Action Planning Sheet" is an optional tool that is great for those persons who may desire to enrich their social network or Circle of Support. Using the planning sheet is a way to organize "how" to think about building natural supports and "where" you can go to do this. A person might want to "have more friends" but perhaps didn't think that volunteering might be a way to meet people who share interests. This tool fosters that creative exploration.

Meetings

"Looking Back and Moving Forward" is a sheet that should be used to capture success and struggles. The sheet should also be used to help plan for future meetings. It can be helpful for identifying necessary team members or timelines for when meetings will take place.

Now What?

You and the person along with the Circles of Support have now worked for quite some time to build the Person-Centered Plan. As is true for people with hopes and dreams, this plan should be active and transformative. It should change when needed and remain at the center of what a person wants and needs. As a facilitator, you should seek consultation from your team to be certain you and the process are remaining true to the principles and ideal of self determination through a Person-Centered Planning process.

Appendix
Connecting Person-Centered Planning to the Development of a Plan of Care

Executive Office of Elder Affairs

Department of Developmental Services (DDS)

Person-Centered Planning and The Individual Support Plan/Plan of Care

Mass Commission for the Blind

Mass Rehabilitation Commission

Mass Commissioner for the Deaf and Hard of Hearing