Living Well In My Community

Part 1:
A Guide to Home and Community Based Service Standards and Person-Centered Practices

How to use Living Well In My Community

Feel free to download this guide to use and share with others. Living Well In My Community was created to help people with disabilities and service providers better understand the rights and roles for living well in the community. Part 1 explains what the Home and Community-Based Services Rule is and how it can help people with disabilities to live in the community like other people without disabilities.

In Part 2, resources from Charting the Life Course can be used to create a vision of a good life in the community. Part 3 describes each characteristic of quality home and community-based services with some reflective questions to assess progress and areas for continued development. Examples of some person-centered approaches are introduced to help individuals with disabilities and providers move in the direction of a person's vision of a good life. The person-centered approaches described in Living Well In My Community will also be helpful to providers in meeting the home and community-based settings requirements. Part 4 has useful tips for working with a planning team to support a vision of a good life through person-centered planning, as well as an array of resources for more information.

HCBS Peer Partners Project Grant

The workbook is funded by a grant from the California Department of Developmental Services. UCP WORK, Inc. is the lead agency, representing a regional project reflecting efforts of multiple providers that support individuals and families in the Tri-Counties Regional Center catchment area. This includes UCP-LA and Villa

Esperanza in Ventura County, UCP WORK, Inc., CPES/ Novelles, and Devereux in Santa Barbara and San Luis Obispo Counties. An ad hoc subcommittee of the TCRC Vendor Advisory Committee, comprised of service providers, regional center staff, and representation from the State Council on Developmental Disabilities (SCDD), implemented a survey of regional service providers. Upon reviewing results, the survey revealed a gap in getting HCBS information as well as Person-Centered Thinking resources to providers in outlying areas operating a small business which serve individuals and families.

The impetus for the efforts of the grant project is in aiding providers to understand how to meet the new HCBS Waiver Community Standards. The greater goal of the standards and this grant project is to support persons with developmental disabilities to have better lives, not just better paper. We endeavor to give the people we support more control over their services, receiving what is important to them: services supporting their own vision for the future and what is important for to be healthy, safe valued, members of their community.

Acknowledgments

Thank you to the many contributors who helped in creating this guide

HCBS Peer Partner Advisory Committee
Dave Mulvey, HCBS Peer Partners Project Coordinator
Diva Johnson, Tri-Counties Regional Center
Harry Bruell, PathPoint
Judy Linares, UCP Work Inc.
Kathy Webb, UCP Work Inc.
Mark O'Keefe, Tri-Counties Regional Center
Mary Beth Lepkowsky, Helen Sanderson Associates USA
Michele Ferrall, CPES/Novelles
Nikisa Simmons UCP-LA
Tina Calderaro-Mendoza, Tri-Counties Regional Center

Living Well In My Community was funded by a grant from the California Department of Developmental Services and includes principles and concepts developed by and used here with permission from The Learning Community for Person-Centered Practices. http://tlcpcp.com/

Stories and examples were contributed by Sue Goss, Diva Johnson, Rebecca Martinez, David Mulvey, Valerie Nix, Michael Kaszycki, Derek Smith and Mary Beth Lepkowsky. Others were generous in giving permission to share a variety of person-centered resources.

Helen Sanderson Associates USA https://helensandersonassociates.com John O'Brien and Beth Mount
http://www.inclusion.com/product/make-a-difference/
Line Plourde-Kelly Kapuskasing & District Association for Community Living (KDACL)
http://www.kdacl.com
Charting the Lifecourse

https://www.lifecoursetools.com

Editors: Mary Beth Lepkowsky, Dave Mulvey, Eugene Baldwin
Translations: Inline Translation Services.
Design: Julie Barclay

May 2020

Contents

What is HCBS?

What are home and community-based services (HCBS)?

HCBS stands for Home and Community-Based Services. Home and community- based services include different kinds of long-term services and supports that help people with disabilities and older adults live everyday lives in their communities.

Some examples of long-term services and supports are:

- Adult day services.
- Job coaches.
- Personal care services to help with day to day activities like eating, bathing, and getting dressed.

Medicaid is a program of the United States federal government that helps people get health care if they don't have a lot of money. Lots of people with disabilities use Medicaid. In California, the Medicaid program is called MediCal.

Medicaid pays for long-term services and supports. Some service providers get money from Medicaid to deliver long term services and supports.

When people get long term services and supports in their community, it is called home and community-based services (HCBS). Home and community-based settings are places where individuals with disabilities live and spend their days; for example, licensed residential settings and day programs. When Medicaid pays for home and community-based services, it helps people with disabilities live in their communities. It helps people with disabilities live the same kind of lives as everyone else.

What is the Home and Community-Based Services Waiver?

Medicaid used to not pay for home and community-based services. People could only get services in institutions. In California some institutions are called developmental centers.

In the 1980's the U.S. government wrote a "waiver" to change the law. The Home and Community Based Services Waiver changed the law to let Medicaid pay for services at home or in the community, not only in institutions or developmental centers.

What is the HCBS Rule? Why is it needed?

Medicaid started paying for home and community-based services. But, nobody decided what would be different about services provided at home or in the community rather than in an institution.

The HCBS Rule was created to explain what home and community-based services should look like, and what they shouldn't look like. It makes sure Medicaid doesn't give HCBS money to programs and services that are really more like institutions.

The HCBS Rule helps people with disabilities live in their communities. It helps them get the kind of services they need. And it helps make sure home and community- based services really are HCBS and not like an institution.

The HCBS Rule also says that all services in every state must follow the new rules by March 2022. After March 2022, the federal government will not pay service providers that do not meet the new rules.

Living Well In My Community, and information provided by HCBS Peer Partners, the regional center, and the Department of

Developmental Services can help individuals with disabilities and service providers understand the new rules and make changes to give people more choice and control in their lives, and also meet the 2022 deadline.

What does the HCBS Rule mean for people?

The purpose of the HCBS Rule is to help people who receive regional center services live full lives in their communities. It helps people with disabilities live the same kind of lives as everyone else.

For people who receive home and community-based services:

The HCBS Rule says that people with disabilities have different options to choose from when making decisions about services and service providers. The HCBS Rule says people with disabilities have the right to:

- Live in the community along with people without disabilities.
- Have a person-centered plan.
- Have freedom.
- Have respect and privacy.
- Not be restrained or secluded.

For service providers

Some service providers may already meet the home and community-based services requirements. Others may find they need to modify policies and program designs, where and how services are delivered, and provide training to assure that staff members understand the expectations of the rules.

The HCBS Rules says that providers have responsibilities for:

- Ensuring that people with intellectual/developmental disabilities are provided the protections that are afforded to all California tenants, commonly known as "Tenant's Rights"
- Ensuring that people are treated with respect and are afforded privacy.
- Supporting people in creating schedules that meet their needs and promote the lives they want to live.
- Ensuring the people have opportunities to have visitors.
- Ensuring that a person's home is accessible to them throughout the day.

Remember, this is a partnership. Everyone wants to have good experiences in their community. People with disabilities, planning team members, service providers, family members, and regional center partners can work together to help everyone have good experiences. Use the person-centered practices described in this guide to make meaningful choices and changes. This will help to ensure that people live well in their community and providers continue to receive federal funding for offering high quality home and community-based services.

What does the HCBS Rule say about home and community-based services?

The HCBS Rule says that home and community-based services must be provided in the community. That means people with intellectual/developmental disabilities have the right to live in the community just like people without disabilities.

Home and Community-Based Settings Requirements Compliance Toolkit
https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-settings-requirements-compliance-toolkit/index.html

What are the qualities of home and community-based settings?

The requirements in the HCBS Rule describe characteristics of quality of home and community-based services. They explain how home and community-based services are supposed to be different than an institution or developmental center.

Quality Requirements of Home and Community Based Services

Quality Requirement #1: Being part of the community

This means that the setting supports someone with a disability to have the same chances to be an active and included member of their neighborhood and community as someone without disabilities. People should have opportunities to:

- find competitive employment working alongside people without disabilities.
- participate in local activities.
- access services in the community just like people without disabilities.

Quality Requirement #2: Choosing where and how I live

This means that the setting supports a person with a disability to choose where and how they live from among options that include settings where people without disabilities live and spend their day. For residential settings, this includes

- having an option for a private room when available.

Quality Requirement #3: Having privacy, dignity and respect

This means a provider setting must support individual rights including privacy, dignity and respect, and freedom from coercion or restraint. Some of the individual rights that a person with a disability has include:

- being able to lock doors to one's room or home.
- using the phone when desired.
- coming and going as one pleases.
- having time alone to have privacy.

Quality Requirement #4: Independence

Independence means that people with disabilities are in charge of making decisions about their life and what they want to do. The provider setting enables people to

- decide how people spend their day.
- set a personal schedule.
- choose where to go.
- control personal resources and individual budget.

Quality Requirement #5: Choosing supports and who provides them

The provider setting supports people to choose their services and who provides them. Choice means that a person can choose what services and supports they need. The person can choose who provides those services and where they are provided. Like most things in life, choices are based on individual needs and preferences as well as the options and resources that are available.

Provider owned or controlled residential services must also meet the following conditions

Residential Condition #1: Tenants' Rights

This means that a person with a disability has the same rights and protections from eviction as other tenants.

Residential Condition #2: Respect and privacy

If people are living in a home owned or controlled by a service provider:

1. They can lock their door.
2. They can choose their roommate.
3. They can decorate where they live within the terms of a lease or other agreement.

Residential Condition #3: Creating personal schedules

The setting enables people to have the freedom and support to control their own schedules and activities and have access to food at any time.

Residential Condition #4: Having visitors

People can have visitors of their choosing at any time.

Residential Condition #5: Accessibility at home

The setting is physically accessible to the individual.

How can person-centered thinking, planning, and practices help?

Person-centered thinking is a set of values, skills and tools that can be used to get to know someone and discover what they find important and what they want out of life. It ensures that we focus on what matters to the people we support and their family, and that we pay attention to their staff as well.

Person-centered planning is an ongoing process to help people with or without disabilities to plan for their future. In person-centered planning, groups of people focus on an individual and that person's vision of what they would like to do in the future.

Through a person-centered planning process, people who know and care about the person often begin to look at the person in a different way. Person-centered planning helps a person gain control over their own life. Person-centered planning can increase opportunities for participating in the community. Person-centered planning helps others recognize a person's gifts, capacities, desires, interests, and dreams. The planning team works together to create action steps to turn a person's dreams into reality.

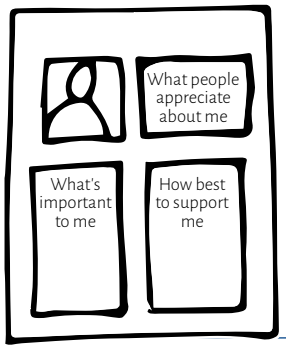
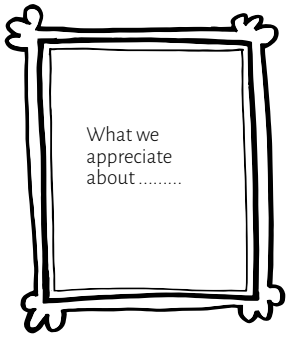
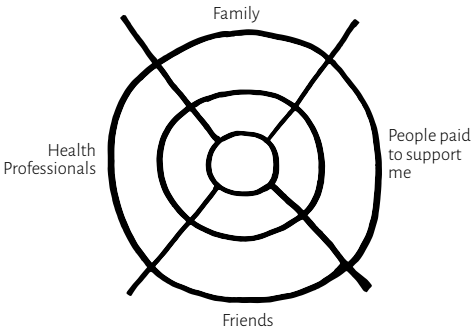
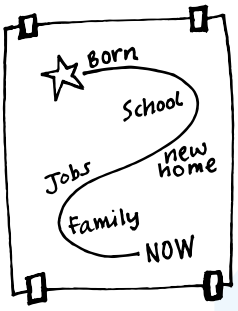
Person-centered practices are ways of planning, providing, and organizing services by listening to what people want and helping them live in their communities based on their choices. Service providers can strengthen their

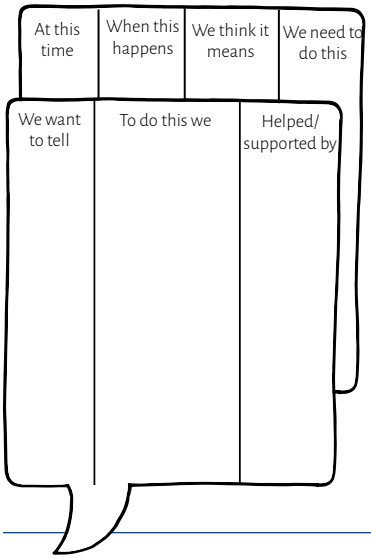
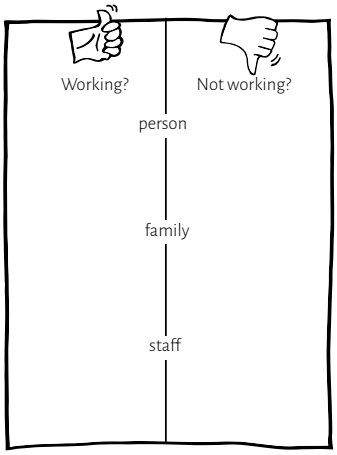
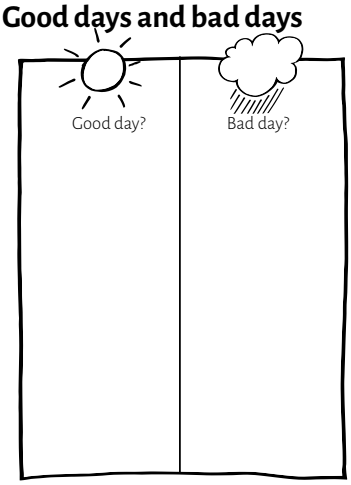
policies and procedures to make it possible for person-centered thinking and planning to flourish.

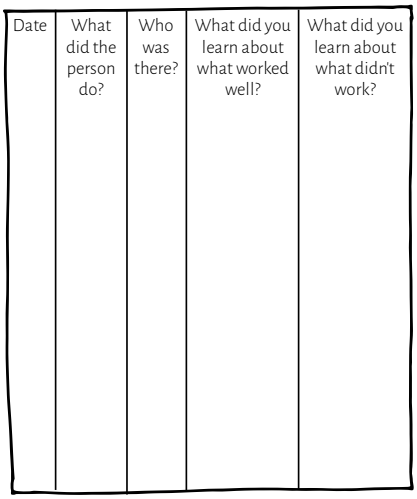
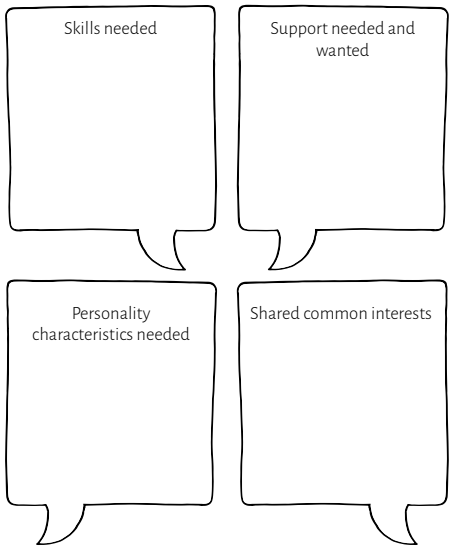
Medicaid will cover home and community-based services (HCBS) only when a person-centered service plan (service plan) is created that addresses the person's long-term care needs as an alternative to institutionalization. Person-centered thinking skills introduced throughout Living Well In My Community, illustrate examples of people with disabilities having more positive choice and control in their lives. The skills offer multiple ways to learn what is important to the person to be happy, content and fulfilled, and what is important for the person to remain healthy, safe and valued by others.

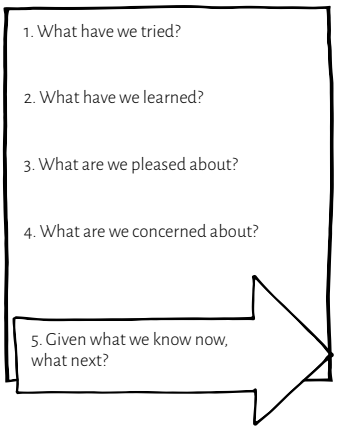
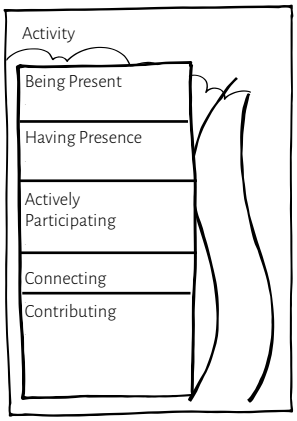
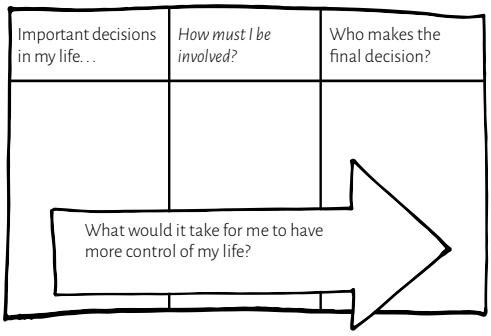
Person -centered thinking skills help service providers learn how a person with a disability wants to be supported to live a life they choose for themselves. Providers will learn new ways to:

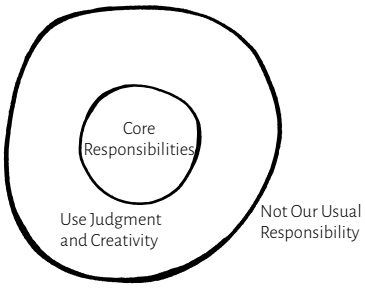
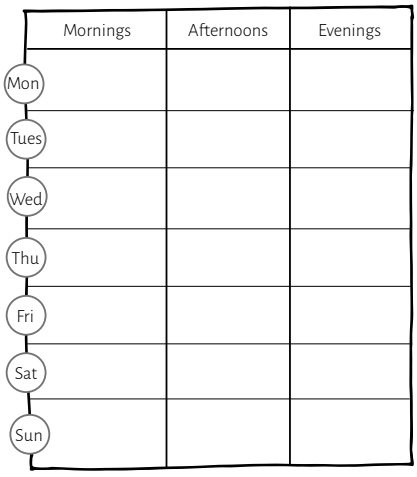
- Support people in ways that make sense to each individual.
- Help people build relationships and make meaningful connections in their community.
- Practice supported decision making.
- Listen to how people communicate their preferences using words and behavior.
- Discover people's gifts, skills, and capacities and think about where those gifts can make valued contribution in the community.
- Provide experiences that support people to become more actively involved in their communities.
- Evaluate risk based on what is important to and important for a person.
- Build a culture of continuous learning in support of a person's vision of a good life.

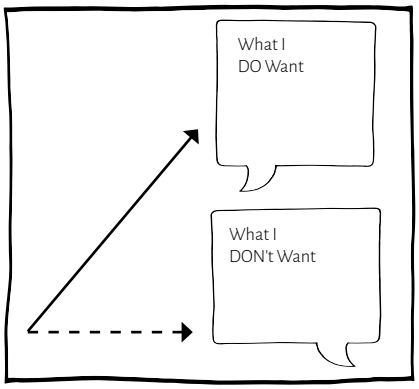
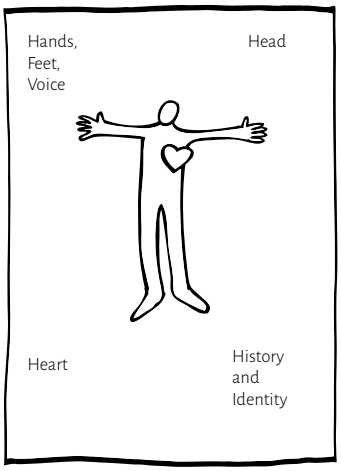
Person-centered thinking skill	What it does	How this person-centered thinking skill helps
One-page profile (sorting important to/for) 	· Separates what is important TO someone (what makes the person happy, content and increases wellbeing), from what is important FOR them (the help or support they need to stay healthy, safe and well) while working towards a balance between the two.	· Identifies what must be present, or absent, in the person's life to ensure they are supported in ways that make sense to them, while staying healthy and safe. A quick summary of who the person is and how to support them for all staff and others. · The basis for making changes using a one-page profile with working/not working.
Appreciations 	· Identifies the qualities that people value and admire about the person. · Helps supporters to see what makes the person unique.	· Acknowledges and appreciates a person's gifts and qualities. · Ensures we see people for who they are and counters the frequent focus on what is wrong. · Identifies those who have a personal connection with the person and those who really know what is important to them. · Part of a one-page profile.
Relationship map 	· Identifies who the important people are in a person's life.	· Shows who is most important to the person. · Sees if there are any important issues around relationships. · Helps identify who to talk to when gathering information. · Identifies relationships that can be strengthened or supported.
Life story/history 	· Our histories make us who we are - with history comes regard. · Gives people the opportunity to understand and appreciate the person in the context of their own story.	· Shows us how best to support the person in the context of their past life which may represent current reality. · Can be used to frame meaningful conversations. · Helps supporters empathize with the person and see their role as ensuring a good quality of life for them.

Person-centered thinking skill	What it does	How this person-centered thinking skill helps
Communication charts 	· A quick snapshot of how someone communicates. Important whenever what the person does, communicates more clearly than what they say.	· Helps us focus on people's communication whether they use words to speak or not. · Provides clear information about how to respond to the way the person communicates.
Working/not working 	· Analyzes an issue or situation across different perspectives. · Provides a picture of how things are right now, and how this compares with the way people want to live and be supported. · Enables us to reflect on what is actually happening in someone's life and to change what needs to be changed.	· Clarifies what to build on (maintain or enhance) and what to change. · Helps in looking at how; any part of a person's life is working, people providing paid support are doing in their work, any effort, activity or project is working. · Helps with negotiation where there are disagreements. · Use to create actions from a one-page profile.
Good days and bad days 	· Explores in detail what makes a good day for a person (i.e. what needs to be present in their daily life) and what makes a bad day (i.e. what needs to be absent).	· Helps the person have more good days and less bad days. · Helps us learn about what is important to someone and how they want to be supported. · Offers another way to gather information for a person's Communication chart, Relationship circle, and Matching support.

Person-centered thinking skill	What it does	How this person-centered thinking skill helps
Learning log  	· Directs people to look for ongoing learning through recording specific activities and experiences to best support someone.	· Provides a way for people to record ongoing learning (focused on what worked well and what didn't work well) for any event or activity. · Tells us what is important to and for individuals and families. · Can replace traditional notes or records to help us see the importance of moving away from focusing on getting tasks done, to truly supporting people to have a good life based on our continual listening and learning. · Can be used to focus on someone's whole life or specific areas of their life, e.g. someone's health, how people like to spend their time.
Matching staff  	· Provides a structure to look at what skills, supports, people characteristics and shared interests make for good matches. This is key to supporting someone well.	· Encourages the person, and those around them, to think about what kind of paid support they want and need when recruiting team members. · Ensures the person likes the people who are supporting them,making it more likely they will have a good quality of life. · Good matches can reduce the likelihood of poor treatment, abuse and neglect. · Promotes staff retention.

Person-centered thinking skill	What it does	How this person-centered thinking skill helps
4 plus 1 questions 	· Helps people focus on what they are learning from their efforts. · Gathers valuable information for future actions and planning · Given this learning, what needs to happen next?	· Gives a structured way for everyone to be listened to and describe what they have learned. · Useful in review meetings and individual work with families. · To review actions from plans and plan further actions.
Presence to contribution 	· Encourages creative thinking about activities and how we can use them as opportunities for participation and contribution. · Identifies activities that the person is already, or wishes to be, involved in.	· Promotes being included, leading life to the full, doing interesting things and making a contribution as a full member of the community.
Decision Making Agreement 	· Helps us to think about decision making and increasing the number and significance of decisions people make.	· Enables people to be in control and to make decisions. · Can inform best interest decision making and advanced decision making.

Person-centered thinking skill	What it does	How this person-centered thinking skill helps
Donut sort  	· Clarifies the roles and responsibilities of the different professionals and agencies supporting people and their families based on what is important to and for the person receiving services.	· Helps staff to be clear about what they must do and where they can be creative when supporting people to live at home.
My places  	· Helps to identify the places that matter in a person's life. · Promotes inclusion and belonging by helping a person be seen as a valuable member of a community or group.	· Increases understanding and helps identify places that are worth paying more attention to; it also helps develop the community map and perfect week.
Perfect Week  	· Provides a detailed description of how a person wants to live, not an unrealistic dream. It includes the important places, interests and people that matter to a person.	· Align Perfect Week with Matching Support to work out the best people to support the person to deliver the perfect week. · Helps you look at best ways to support by thinking about family, friends, community initiatives, assistive technology and paid support. · Serves as an evaluation tool for teams to see how well they are delivering personalized support and achieving the right outcomes for the person.

Person-centered thinking skill	What it does	How this person-centered thinking skill helps
LifeCourse Trajectory (visioning tool)  	· Creates a vision of the future a person DOES want as well as the future the person DOES NOT want. · Learn more about Charting the LifeCourse at lifecoursetools. com	· Helps a person and their family to think about the future · Encourages people to reflect on past experiences and decisions that may have helped or hindered progress toward the life the person DOES want · Looks at different domains of living and various stages in life to reflect on age-appropriate activities and resources.
Gifts and capacities  	· Explores gifts and capacities and what a person has to contribute. · Informs us as to what is important To and For a person · Contributes to the positive reputation of a person. · Provides insight on future possibilities for connections and belonging.	· Encourages us to think about situations where the person can best make a contribution and be seen as a valuable member of their community.

Things I want to remember

HCBS Peer Partner Project

UCP United Cerebral Palsy WORK, Inc.

BDS

The Learning Community

Tri-Counties Regional Center

helen sanderson associates USA

Living Well In My Community

Part 2:
Creating a Vision of a Good Life in My Community

How to use Living Well In My Community

Feel free to download this guide to use and share with others. Living Well In My Community was created to help people with disabilities and service providers better understand the rights and roles for living well in the community. Part 1 explains what the Home and Community-Based Services Rule is and how it can help people with disabilities to live in the community like other people without disabilities.

In Part 2, resources from Charting the Life Course can be used to create a vision of a good life in the community. Part 3 describes each characteristic of quality home and community-based services with some reflective questions to assess progress and areas for continued development. Examples of some person-centered approaches are introduced to help individuals with disabilities and providers move in the direction of a person's vision of a good life. The person-centered approaches described in Living Well In My Community will also be helpful to providers in meeting the home and community-based settings requirements. Part 4 has useful tips for working with a planning team to support a vision of a good life through person-centered planning, as well as an array of resources for more information.

HCBS Peer Partners Project Grant

The workbook is funded by a grant from the California Department of Developmental Services. UCP WORK, Inc. is the lead agency, representing a regional project reflecting efforts of multiple providers that support individuals and families in the Tri-Counties Regional Center catchment area. This includes UCP-LA and Villa

Esperanza in Ventura County, UCP WORK, Inc., CPES/ Novelles, and Devereux in Santa Barbara and San Luis Obispo Counties. An ad hoc subcommittee of the TCRC Vendor Advisory Committee, comprised of service providers, regional center staff, and representation from the State Council on Developmental Disabilities (SCDD), implemented a survey of regional service providers. Upon reviewing results, the survey revealed a gap in getting HCBS information as well as Person-Centered Thinking resources to providers in outlying areas operating a small business which serve individuals and families.

The impetus for the efforts of the grant project is in aiding providers to understand how to meet the new HCBS Waiver Community Standards. The greater goal of the standards and this grant project is to support persons with developmental disabilities to have better lives, not just better paper. We endeavor to give the people we support more control over their services, receiving what is important to them: services supporting their own vision for the future and what is important for to be healthy, safe valued, members of their community.

Acknowledgments

Thank you to the many contributors who helped in creating this guide

HCBS Peer Partner Advisory Committee
Dave Mulvey, HCBS Peer Partners Project Coordinator
Diva Johnson, Tri-Counties Regional Center
Harry Bruell, PathPoint
Judy Linares and Kathy Webb, UCP Work Inc.
Mark O'Keefe, Tri-Counties Regional Center
Mary Beth Lepkowsky, Helen Sanderson Associates USA
Michele Ferrall, CPES/Novelles
Nikisa Simmons UCP-LA
Tina Calderaro-Mendoza, Tri-Counties Regional Center

Living Well In My Community was funded by a grant from the California Department of Developmental Services and includes principles and concepts developed by and used here with permission from The Learning Community for Person-Centered Practices. http://tlcpcp.com/

Stories and examples were contributed by Sue Goss, Diva Johnson, Rebecca Martinez, David Mulvey, Valerie Nix, Michael Kaszycki, Derek Smith and Mary Beth Lepkowsky. Others were generous in giving permission to share a variety of person-centered resources.

Helen Sanderson Associates USA
https://helensandersonassociates.com
John O'Brien and Beth Mount
https://inclusion.com/product/make-a-difference-a-guidebook-for-person-centered-direct-support/
Line Plourde-Kelly Kapuskasing & District Association for Community Living (KDACL)
http://www.kdacl.com
Charting the Lifecourse
https://www.lifecoursetools.com

Editors: Mary Beth Lepkowsky, Dave Mulvey, Eugene Baldwin
Translations: Inline Translation Services.
Design: Julie Barclay

May 2020

Contents

Having Choice and Control In My Life

SKILL: Important To and For

For someone to have more choice and personal control in life, it's helpful for them to think about what kind of life they want to have.

One way to think about what matters most is to consider what is Important to a person and what is Important for a person. Then look to find a balance between both.

Important To

What is important to a person includes those things in life which help us to be satisfied, content, comforted, fulfilled, and happy. Discover what's important to someone by the way they respond, with their words or with their behavior, to these kinds of questions.

- Who are the important people in the person's life? How often do does the person see these people, and what do they do when they're together?
- What gives the person purpose and meaning? What helps them feel fulfilled?
- What are the person's routines and rituals?
- What are some favorite things, prized possessions that the person would not want to be without?
- What are this person's favorite places to go? Things to do?
- What helps someone have status and control in their life?
- How do they like to go about their day? What is their rhythm and pace of life?

SKILL: Important To and For

Important For

What is important for people includes those things that we need to be healthy, safe, and valued in our community.

Some ways to think about what's important for a person is to explore responses to these types of questions:

What does the person need to have, know, or do

- to prevent illness?
- to treat an illness or medical condition?
- to be safe in the community?
- to promote physical and emotional wellbeing?
- to be free from fear?

What do others see as necessary to help the person be a valued and contributing member of their community?

Finding balance

Recognizing what's important to and important for a person and the balance between them is a core concept of person-centered practice. Supporting someone well depends on a solid foundation of understanding what is important to the person and what is important for the person.

Service providers do a very good job of paying attention to what is important for people to be healthy and safe. Sometimes providers may not know how to gather and respond to information about what is important to a person. People with disabilities may be healthy and safe, but they may also be unhappy. That's not a great way to live.

Home and community-based services are expected to do more than help people be healthy and safe. They are expected to help people to live in a way that reflects what is important to them, while also being healthy and safe according to what is important for them. That's what finding balance means.

Having Choice and Control In My Life

SHARING STORIES

SKILL: Important To and For

Maria

Maria is a good-natured person. She likes being outdoors and is very social. For a long time, Maria didn't like going to her planning and review meetings. It seemed all anyone wanted to talk about was her weight - how she failed to meet her weight loss goals, follow her diet, or was not using her treadmill to exercise. Her support team was equally frustrated in their lack of success in helping Maria manage her weight and keep her diabetes in check.

A new planner joined Maria's team who really listened to Maria. The planner asked Maria if those were the topics she wanted to be talking about during her planning team meetings. Maria said, "Absolutely not!"

So, the planner found a way to gather necessary health information outside of the planning team meetings, and instead, asked Maria to take the lead on what was discussed. The conversations started focusing on what was important to Maria, the things she really enjoyed. With this change of focus the team quickly learned that Maria really loved dogs. Maria was not able to have dogs where she lived, but she loved any opportunity to play with other people's dogs in the park or elsewhere. To support Maria in having the opportunity to be around dogs, the team found out that a local dog shelter was in need of volunteers.

Maria became a volunteer dog walker. She loved walking the dogs, though she still did not want to walk for exercise. Maria was so focused on her new volunteer work that she was less focused on food and snacking. She lost weight, and her overall health and outlook on life improved. Maria became a valued contributor at the animal shelter. And now Maria looks forward to her planning and review meetings. Maria's support staff have learned to actively look for opportunities to connect what is important for other people they support to what they have learned about what is important to them.

What is Important TO Maria?

- Spending time with dogs.
- Being a helper.
- Being recognized for her volunteer efforts.

What is Important FOR Maria?

- Maintaining a healthy weight.
- Regular exercise.
- Healthy diet.

What else do you need to learn / know?

- How can we increase Maria's opportunities to work with dogs?
- Is there an opportunity for paid work (dog walker)?
- Is there an opportunity to build friendships?

Having Choice and Control In My Life

SKILL: Important To and For

What is Important TO me?

What is Important FOR me?

What else do you need to learn / know?

HOW TO DO IT

SKILL: One-Page Profile

What it does

What is a one-page profile? A one-page profile is a starting point to summarize what we know matters to a person (what is important to) and how to support them well (including what is important for). The experts on the content of a person's one-page profile is the person themselves and people who love and care most about them. The one-page profile also shares what others appreciate about the person.

How it helps

Why do we have one-page profiles? So that we know what is important to each of us and how to best support one another. We all have gifts and qualities, and things that are important to us; and, we all require support that is individual to us. One-page profiles help us to share this information with others, our family, friends, direct supporters, managers and colleagues so that we can get to know each other better and support each other well.

Michael's One-Page Profile

Michael is a strong advocate for himself and others. He's caring, funny and charming, and loves to socialize with friends. Michael gets help with personal care at home. When first meeting Michael, it can be hard to understand his speech, so he created this one-page profile to help his direct support staff get to know him better and learn how to provide good support.

What One-Page Profile Sections Are, and Aren't

What people like and admire about me...

What this section isn't
A list of accomplishments or awards - instead it is a summary of your positive characteristics.

What this section is
What is good about you? What do others value about you? What are the positive contributions that you make?

What is important to me...

What this section isn't
Simply a list of things you like - instead it is a summary of what really matters to you.

What this section is
A summary of what matters to you. This tells people what is important to you. What your hobbies, interests and passions are. Who is important to you and what makes a 'good' day for you.

How best to support me...

What this section isn't
A list of general hints - instead it is the specific information that would be useful for other people to know about to make sure you feel supported.

What this section is
The specific information that would be useful for other people to know and do if they are to support you in the best possible way.

Having Choice and Control In My Life

SKILL: One-Page Profile

Michael

What people appreciate about me

I am a good advocate for myself
Great sense of humor
Great memory for details
Long friendships
Hard working, never gives up
Friendly, kind, outgoing
Knowledgeable

What's important to me

- My twin brother Bill who lives in Orange County. We talk by phone several times a week around 3pm.
- Diane and Jennifer, I see them once in a while, not on a regular basis.
- Leslie, who used to work with me for about a year, I text her periodically.
- Talking every other week with Mary Beth or Raquel to prepare the agenda for BDC.
- Deciding what to do each day. Sometimes I like to walk to the grocery store or to the donut shop near where I live. I'll buy a few candy bars, especially Hershey's without almonds, and Reese's peanut butter cups.
- I like to eat dinner at 3pm before my staff leaves. Some favorite meals are Eggo waffles, burritos and guacamole, or a plain tortilla with guacamole and hot sauce.
- I love watching sports on TV, my favorite teams are the Golden State Warriors, San Francisco Giants, San Francisco 49ers, and the San Jose Sharks. I have an MLB Pass for baseball and an NBA pass with the home and away guide for basketball. I like the home channel, not the away channel. And I use an Amazon Firestick to stream the games I want to watch.
- I try to travel to see a game at least once a year.
- It's important that people let me finish my own sentences and don't interrupt me. It's OK for people to try to figure it out, at meetings especially…people who've known me for a long time, like the people at the regional center or Manuel, they will get what I'm saying.
- I don't have a regular bedtime; I go to bed when I want. I'll let you know when I want help.

How to support me

- Be patient with my speech disability and hear me out. When I ask you to do something, do it. Repeat back what I've said to check for understanding. Do not talk over me, I am in charge.
- If you don't know me and don't know what I'm saying be patient and try to figure it out. Let me try to spell it out for people. If I go through the alphabet, sometimes people will figure it out, like people at the regional center.
- Place my phone as close as possible to me on my left side. If you are working with me at a meeting, or when you are helping me with meals, it's better if you sit on my left side. Let me know when you are behind me so I won't get startled. When I'm having a drink, let me know if you are right behind me or I might knock it out of your hands.
- Keep the TV tuned to the home channel at all times, especially when I'm waiting for a game. If I don't have on the right channel I get nervous.
- At night, pack the things I gather for the next day and please don't wait until the last minute. Make sure my cell phone is charged and packed, along with sunscreen, water and anything else I might need for the day.
- Learn how to program my communication device and operate my streaming device (Amazon Firestick)
- Don't watch my TV in the living room when I am not there.
- The best time for you to make your phone calls or check your phone/emails is while I am talking on the phone with others. If you are using your phone make sure you are interacting with me and not tuning me out, I may need your assistance.
- When I get mad, I raise my hands up and I can get mean. I will calm down on my own. It also helps a lot when I call my counselor. Hand me my phone and then give me space. What also really helps is to have a glass of wine or a beer. I'll ask for it if I want it.
- It's best if you show up for your overnight shift at 11pm, which is your start time. I'd prefer that you don't show up two hours before your shift and hang out on my couch waiting for your shift to start.

SKILL: One-Page Profile

How to use it

Getting Started with One-Page Profiles

To create a one-page profile, have a conversation to discover what's important to the person. Almost any topic of conversation can help to discover information about what matters to someone and how they want to be supported. These questions are a good place to start.

What's important to me...

1. Who are the most important people in your life? How often do you see them and what do you like to do together?
2. What would make a good day for you at work or at home? What would make a bad day for you at work or at home?—list three things for each.
3. What do you usually do each day or week that you would miss if you didn't do?
4. What makes you stressed, unhappy or upset? How would other people know and what can they do to help?
5. What are some of the things you can't do without, the possessions you value and treasure?
6. What are the beliefs, values or traditions that reflect your culture and identify that you would like others to understand?

Write brief responses to these questions in the section called "What's important to me..."

How to support me well...

For each of the questions above, ask "What do others need to know or do to make sure the things you stated above are present in your day to day life at work, at home, or in your community?" Write the responses in the one-page profile under the heading of "How to support me well."

What people like and admire about me...

7. How would you describe or introduce yourself? What are your skills, talents, things you are good at or want to be known for?

   Invite friends and family to help answer the next question. If they aren't present, call or text them and ask them to answer the question. It will be nice to hear what people say.

8. What would your family and friends say they like and admire about you?

Add the responses to the section of the one-page profile called "What people like and admire about me..."

This will create an initial one-page profile that can change over time as priorities change or when used for different purposes.

SKILL: One-Page Profile

My name

My photo

What people like and admire about me

What is important to me

How to support me well

My Vision of a Good Life In My Community

SKILL: Tool for Creating a Vision

My vision of a good life in my community

Everyone wants to have a good life. Everyone defines a good life in their own way. People define their good life based on things that are important to them and important for them.

What it does

The worksheets on the next few pages, called "Tool for Developing a Vision" can be helpful when creating a vision of the future. It can help service providers think about how to support someone to move closer to the life they DO want and avoid moving toward the life they DON'T want.

How it helps

This resource can be shared with a person receiving supports, family members, and people who love and care about the person, to reflect on and contribute to a vision of the future. This is not intended to be a facilitated conversation, rather it includes a set of questions to think about.

How to use it

To create a vision of the future for yourself or assist a person with thinking about and writing down their vision of their future:

- Take the time to carefully explore what is important to the person and their loved ones.
- Take the time to discover different ideas, and consider what future vision will work best for current circumstances.
- Use one or more of the different parts of life (called domains) to get started with your vision.

My Vision of a Good Life In My Community

SKILL: Tool for Creating a Vision

CHARTING the LifeCourse

Tool for Developing a Vision – Individual

Forming a vision and beginning to plan for the future in each of the life domains helps plot a trajectory for a full, inclusive, quality life in the community. This tool is to help individuals with disabilities of all ages think about a specific vision in each life domain for how they want to live their adult life, and prioritize what they want to work on right now that will help move toward the life vision.

LIFE DOMAIN		My Vision for My Future	priority	Current Situation/Things to Work On
Daily Life Employment	What do I think I will do/want to do during the day in my adult life? What kind of job/career might I like?			
Community Living	Where would I like to live in my adult life? Will I live alone or with someone else?			
Social & Spirituality	How will I connect with spiritual and leisure activities, and have friendships and relationships in my adult life?			
Healthy Living	How will I live a healthy lifestyle and manage health care supports in my adult life?			
Safety & Security	How will I stay safe from financial, emotional, physical or sexual harm in my adult life?			
Citizenship & Advocacy	What kind of valued roles and responsibilities do/will I have, and how do/will I have control of how my own life is lived?			
Supports for Family	How do I want my family to still be involved and engaged in my adult life?			
Supports & Services	What support will I need to live as independently as possible in my adult life, and where will my supports come from?			

Developed by the UMKC Institute for Human Development, UCEDD. More tools and materials at lifecoursetools.com MAY 2016

My Vision of a Good Life In My Community

SKILL: Tool for Creating a Vision

CHARTING the LifeCourse

Tool for Developing a Vision - Family

Forming a vision and beginning to plan for the future in each of the life domains helps plot a trajectory for a full, inclusive, quality life in the community. This tool is to help families of all ages – those with a very young child, an adult or somewhere in between, start to think about a vision for how their family member will live their life as an adult.

LIFE DOMAIN		My Vision for My Family Member's Future	priority	Current Situation/Things to Work On
Daily Life Employment	What do I think my family member will do during the day in his/her adult life?			
Community Living	Where and with whom do I think my family member will live in his/her adult life?			
Social & Spirituality	How will he/she connect with spiritual and leisure activities; have friendships & relationships in his/her adult life?			
Healthy Living	How will he/she live a healthy lifestyle and manage health care supports in his/her adult life?			
Safety & Security	How will I ensure safety from financial, emotional, physical or sexual harm in adult life?			
Citizenship & Advocacy	How can I make sure he/she has valued roles and responsibilities, and has control of how his/her own life is lived as an adult?			
Supports for Family	What will our family need to help support him/her to live a quality life as an adult?			
Supports & Services	How will he/she be supported in adult life to lead the kind of life he/she wants as independently as possible?			

Developed by the UMKC Institute for Human Development, UCEDD. More tools and materials at lifecoursetools.com MAY 2016

My Vision of a Good Life In My Community

SKILL: Tool for Creating a Vision

CHARTING the LifeCourse

Tool for Supporting a Vision - Service Provider

Forming a vision and beginning to plan for the future in each of the life domains helps plot a trajectory for a full, inclusive, quality life in the community. This tool is to help HCBS service providers start to think about how they can support each person's vision to live their life as an adult.

LIFE DOMAIN		How we can support _____'s Future	priority	Current Situation/Things to Work On
Daily Life Employment	What does this person want to do during the day in his/her adult life? How can we help make it happen?			
Community Living	Where and with whom does this person want to live in his/her adult life?			
Social & Spirituality	How does this person want to connect with spiritual and leisure activities; have friendships & relationships?			
Healthy Living	What is our role in supporting How will him/her/them to live a healthy lifestyle and manage health care supports?			
Safety & Security	How will we support him/her/them to be safe from financial, emotional, physical or sexual harm?			
Citizenship & Advocacy	How can we make sure he/she/they have valued roles and responsibilities, and control of how his/her/their own life is lived?			
Supports for Staff	What will our staff need to help support him/her to live a quality life as an adult?			
Supports & Services	How will we support our team to help him/her/them to lead the kind of life he/she/they want as independently as possible?			

Developed by the UMKC Institute for Human Development, UCEDD. More tools and materials at lifecoursetools.com MAY 2016

My Vision of a Good Life In My Community

HOW TO DO IT

SKILL: LifeCourse Trajectory

What it does

A trajectory is a path. The LifeCourse Trajectory helps individuals and families think about the future. First think about the future that the person with a disability DOES want. Next, think about the future that the person DOES NOT want. Then use the space around the arrows to write down the actions and experiences that will help move toward that vision of a good life. It can also help to write down the actions and experiences that might keep the person on a path to the life they don't want, so those can be avoided when possible.

How it helps

A vision of a good life can be for a long time in the future. Some people might choose to think about where they want to live in three years? Or what kind of future job would make them happy and fulfilled?

A vision of a good life can also be for a much shorter time in the future. In "Derek's Trajectory for the Next Few Weeks", Derek talked with his mother to create a vision of his good life for the next few weeks to help him feel happy, safe, and connected to friends and family while he had to stay home during the coronavirus pandemic. There were lots of sudden changes to his routine and Derek found that having a vision and a plan helped him get through a stressful time.

How to use it

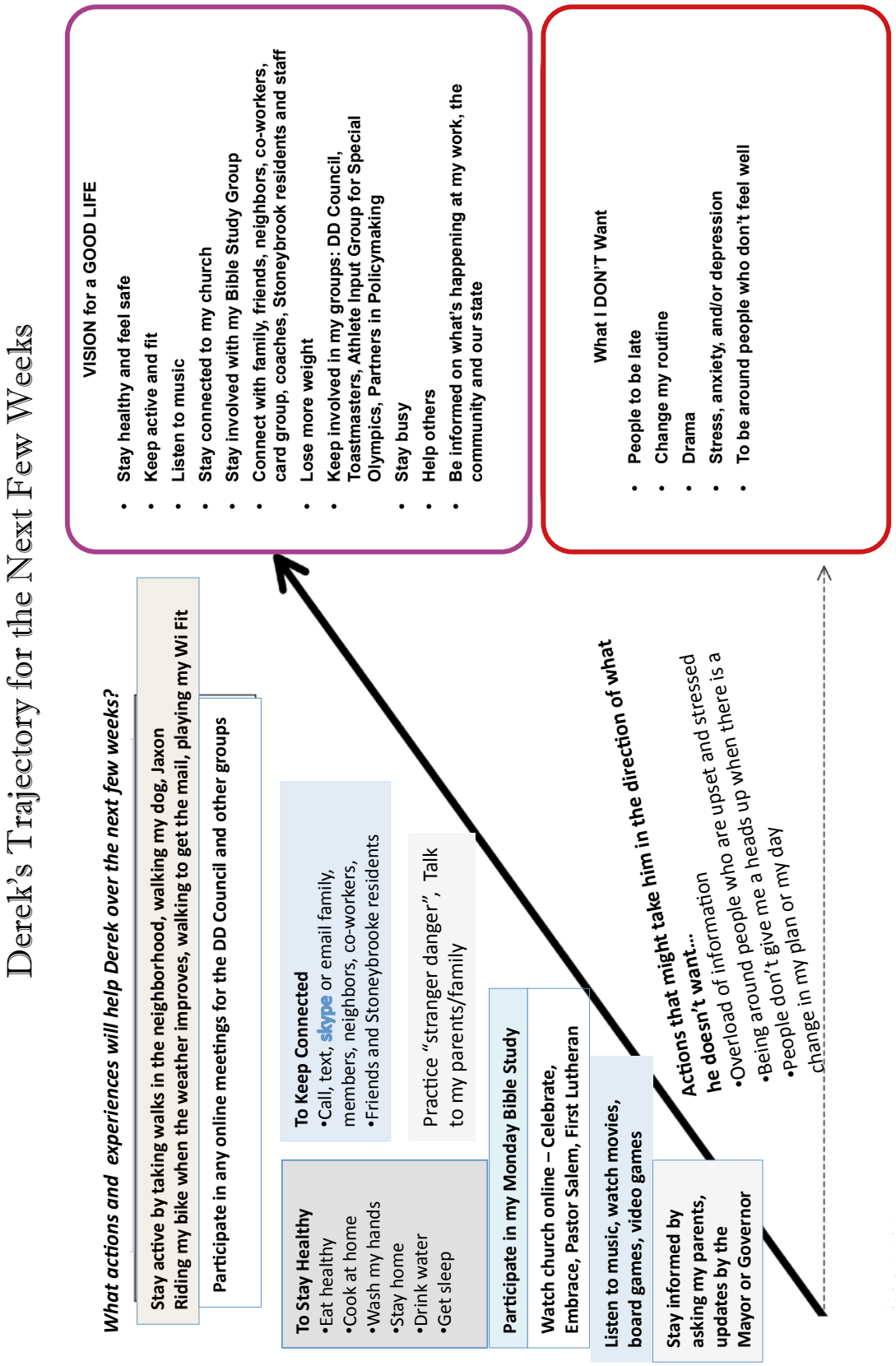
Look at Derek's example on the next page. Use the blank worksheet to create your vision for your good life.

1. To get started, look at the blank Trajectory worksheet that follows Derek's example.
2. Pick one or more areas of your life you want to plan for and write them down on the left side of the worksheet. You might pick areas from your completed Tool for Supporting a Vision worksheet. You might also pick different areas depending on what matters to you.
3. Next, write down what you do want and don't want in that part of your life on the right side of the Trajectory worksheet.
4. Share your vision for the future with your planning team. They can help you create an action plan to move in the direction of your vision.
5. The Tool for Creating a Vision and the LifeCourse Trajectory work really well with all of the other person-centered thinking skills. Here are some of their benefits:

- They add to your understanding of what's important to and important for a person.
- They can provide insights about who would be a good match for a person.
- They can offer information about someone's gifts and skills.
- They provide ideas for potential or different opportunities for building meaningful connections in the community.
- They can help the person and the planning team to think creatively about outcomes and supports that are needed to live a meaningful life defined by the individual.

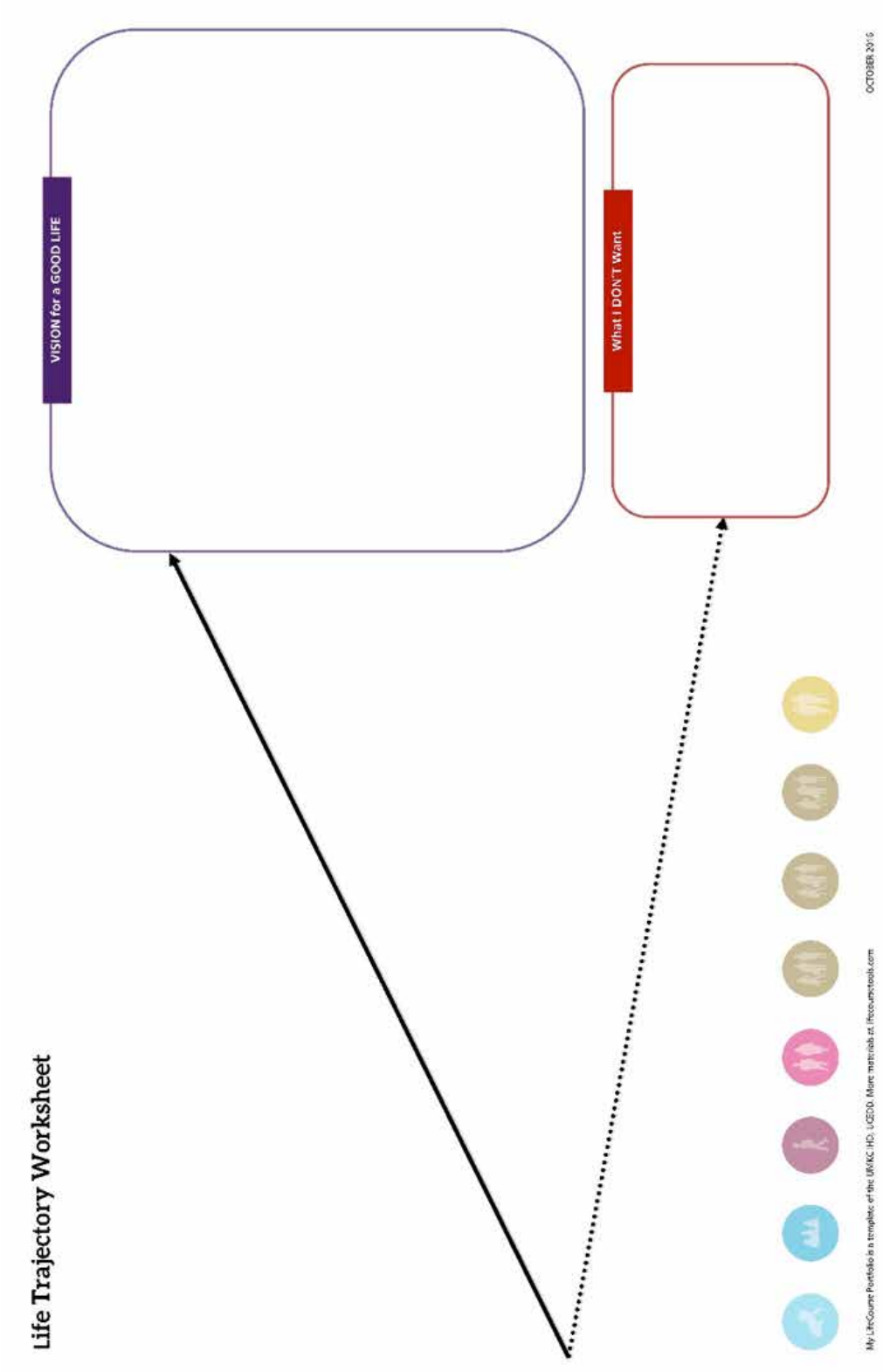
My Vision of a Good Life In My Community

SKILL: LifeCourse Trajectory



My Vision of a Good Life In My Community

SKILL: LifeCourse Trajectory



Things I want to remember

Things I want to remember

Living Well In My Community

Part 3:
Characteristics of Quality in Home and Community-Based Services

How to use Living Well In My Community

Feel free to download this guide to use and share with others. Living Well In My Community was created to help people with disabilities and service providers better understand the rights and roles for living well in the community. Part 1 explains what the Home and Community-Based Services Rule is and how it can help people with disabilities to live in the community like other people without disabilities.

In Part 2, resources from Charting the Life Course can be used to create a vision of a good life in the community. Part 3 describes each characteristic of quality home and community-based services with some reflective questions to assess progress and areas for continued development. Examples of some person-centered approaches are introduced to help individuals with disabilities and providers move in the direction of a person's vision of a good life. The person-centered approaches described in Living Well In My Community will also be helpful to providers in meeting the home and community-based settings requirements. Part 4 has useful tips for working with a planning team to support a vision of a good life through person-centered planning, as well as an array of resources for more information.

Acknowledgments

Thank you to the many contributors who helped in creating this guide

HCBS Peer Partner Advisory Committee
Dave Mulvey, HCBS Peer Partners Project Coordinator
Diva Johnson, Tri-Counties Regional Center
Harry Bruell, PathPoint
Judy Linares, UCP Work Inc.
Kathy Webb, UCP Work Inc.
Mark O'Keefe, Tri-Counties Regional Center
Mary Beth Lepkowsky, Helen Sanderson Associates USA
Michele Ferrall, CPES/Novelles
Nikisa Simmons UCP-LA
Tina Calderaro-Mendoza, Tri-Counties Regional Center

Living Well In My Community was funded by a grant from the California Department of Developmental Services and includes principles and concepts developed by and used here with permission from The Learning Community for Person-Centered Practices. http://tlcpcp.com

Stories and examples were contributed by Sue Goss, Diva Johnson, Rebecca Martinez, David Mulvey, Valerie Nix, Michael Kaszycki, Derek Smith and Mary Beth Lepkowsky. Others were generous in giving permission to share a variety of person-centered resources.

Helen Sanderson Associates USA
https://helensandersonassociates.com
John O'Brien and Beth Mount
http://www.inclusion.com/bkmakeadifference.html
Line Plourde-Kelly Kapuskasing & District Association for Community Living (KDACL) http://www.kdacl.com
Charting the Lifecourse https://www.lifecoursetools.com

Editors: Mary Beth Lepkowsky, Dave Mulvey, Eugene Baldwin
Translations: Inline Translation Services. Design: Julie Barclay

May 2020

Contents

Part 3: Characteristics of Quality in Home and Community-Based Services

Quality Requirements of HCBS Services

There are five quality requirements in the HCBS Rule, each described in three sections:

- The first section describes what the requirement means.
- The second section asks how well this requirement is being met and what needs to happen to improve.
- The third section lists helpful person-centered thinking skills, some of which will be featured with examples.

Being Part of the Community

Quality Requirement #1: Being Part of the Community

This means that people with disabilities have the same opportunity to be an active and included member of their neighborhood and community as someone without disabilities. People should have opportunities to:

- find competitive employment working alongside people without disabilities.
- participate in local activities.
- have services provided in the community just like people without disabilities.

How are you doing?

Does the provider support the person to spend time in places where other people living in your community go? (examples: stores, restaurants, bank, places of worship)	Yes	No
Does the provider support the person to do what they want in their community? (examples: go to a gym, visit the library, take a class)	Yes	No
Do individuals receive services in the same places as people without disabilities?	Yes	No
Does the provider support the person to do as much as they want in the community?	Yes	No

If answered "no," what changes could be made so that people have more chances to be part of the community?

Person-centered thinking tools and practices that can help

Featured examples to achieve quality in this area

- Gifts and Capacities "Who am I?"
- Community Mapping
- Presence to Contribution
- What Happens Here

Other skills that can be useful in gathering and documenting information

- Important to / Important for
- Matching
- Routines & Rituals
- Good Day / Bad Day
- Working / Not Working
- Decision-Making Profile
- Decision-Making Agreement

Being Part of the Community

SKILL: Gifts and Capacities: "Who Am I?"

HOW TO DO IT

What is does

Explores gifts, skills and capacities, what a person is good at and what qualities they have to contribute.

How it helps

Encourages us to think about situations where the person can make a contribution to others.

How to use it

Invite the person to talk about a time when something they did made a positive difference for others and gave the person a "good feeling."

Build on this with stories, from others who know them well, about when the person is at their best.

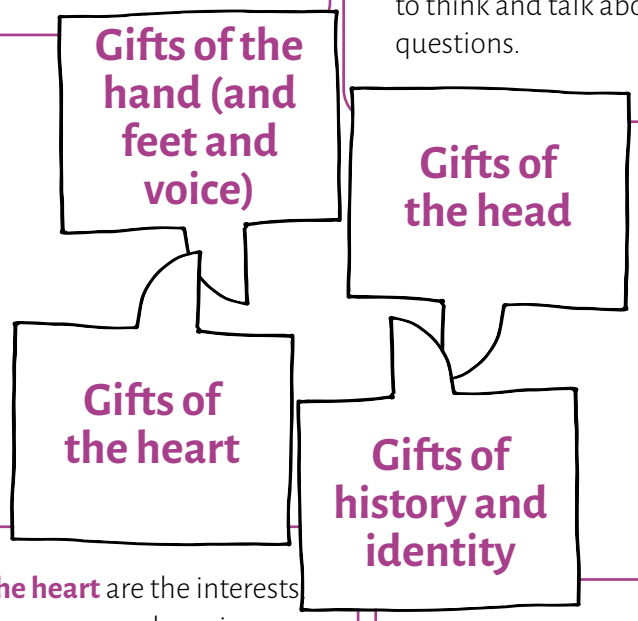
Consider what this tells us about the person's gifts, skills, and contributions.

Gifts of the hand (and feet and voice) are abilities and skills that a person can contribute. These might include:

- dancing, singing, acting.
- typing, drawing, arranging shapes and colors, decorating
- using a computer.
- composing music, sewing.
- working hard, using physical strength.
- ability to sign, ability to speak or understand another language.

Gifts of the head include the knowledge, questions, experience, and information that a person can contribute. These include:

- figuring people out, organizing and classifying things.
- travel routes, sports news, fan information, gossip.
- local history, trivia.
- creative thinking, math, solving puzzles.
- interest in politics, desire to think and talk about big questions.



Gifts of the heart are the interests, enthusiasms, personal passions, and the rewards of relationship that someone brings to others, such as:

- welcoming people, patience, courage, impatience to move from talk into action.
- sensitivity to others, high energy, desire for order, ability to listen.
- passion for justice, love of nature, ability to draw others out, spiritual gifts.

Gifts of history and identity include the experiences, knowledge, duties, responsibility concerns, types of belonging that come with membership in a family, religion, national or ethnic group, citizenship, or member of a club.

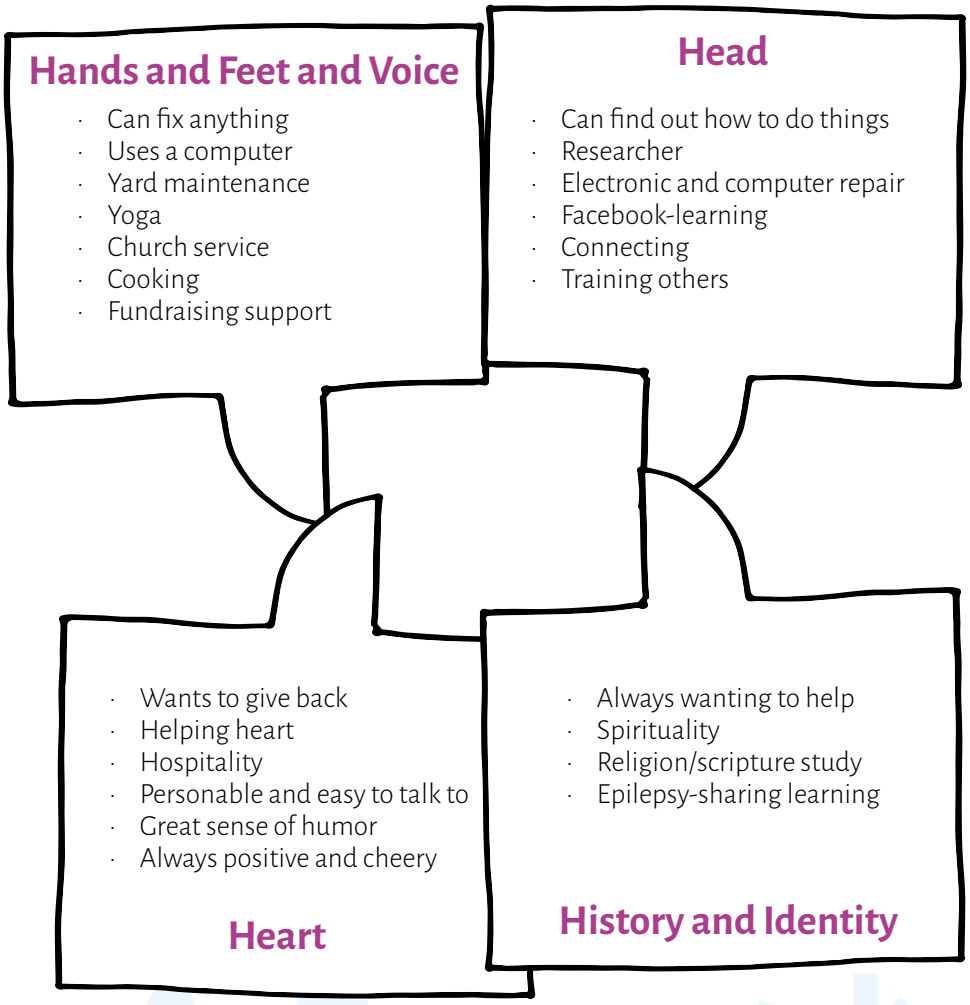
SHARING STORIES

SKILL: Gifts and Capacities: "Who Am I?"

Tyler

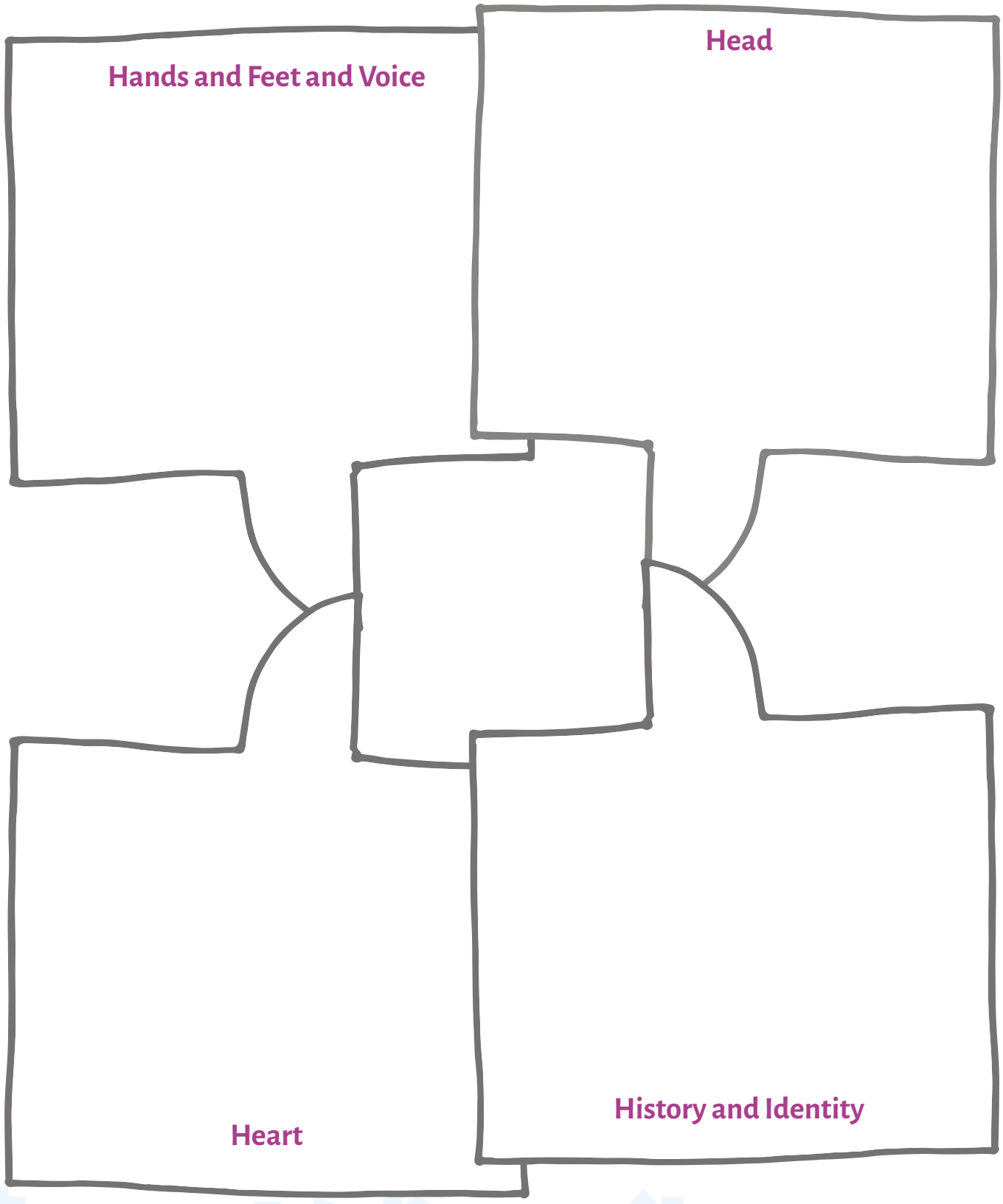
Tyler's support staff looked at great things about Tyler that might be useful in building connections with and supporting his local community. They learned that Tyler loves to be around people and loves to help.

His religion and spirituality are very important to him and he loves to share that. Tyler is a very handy guy to have around; he can fix almost anything. Tyler likes to be on the go, so make a plan and get going!



Being Part of the Community

SKILL: Gifts and Capacities: "Who Am I?"



HOW TO DO IT

SKILL: Community Mapping

What it does

Community mapping gives a graphic representation of what is happening in the community - places and people. It is a way to learn about the possible associations in your community.

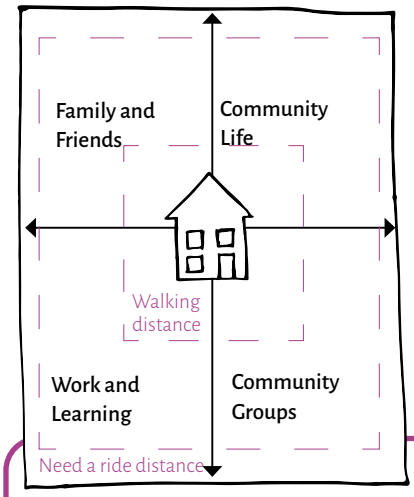
How it helps

It helps to discover what is unique about the community and common gathering places. It finds out what people do for fun, where people feel valued and welcomed. It identifies the various organizations and networks in your local community. It matches the person's interests, gifts and skills with what is present in the community.

How to use it

Invite people to create a map that includes significant places and people. Gather information by talking to others, checking out newspapers, newsletters, and the internet. Ask:

- What places don't require transportation?
- What places do require transportation?
- What are the major streets for shopping and entertainment?
- What are the public places (community centers) where people go?
- Where is the center of the community?
- What are favorite places to shop?
- What is unique to your community?
- Where are the informal places that people hang out?
- Who are helpful people and where can they be found?



New to a community? Check with your Chamber of Commerce, Welcome Wagon, or Parks and Recreation. Find a local resource person to help you build your map.

The template shown here looks at opportunities to build community connections and sorts them by those that do and do not require transportation.

Additionally, the template encourages you to look at different aspects of community life:

- Family and Friends,
- Community Life,
- Work and learning opportunities, and
- Community Groups.

Your map should focus on what is important to the individual you are supporting in addition to providing them with new opportunities to try.

Supporting people in becoming valued members of their community requires that we develop an understanding of where opportunities exist in the local community to build connections. There are many ways to develop community maps.

- You can pin flags to a paper map
- Use Google Maps or Google Earth to build custom map overlays.
- Choose a style of mapping and give it a try.

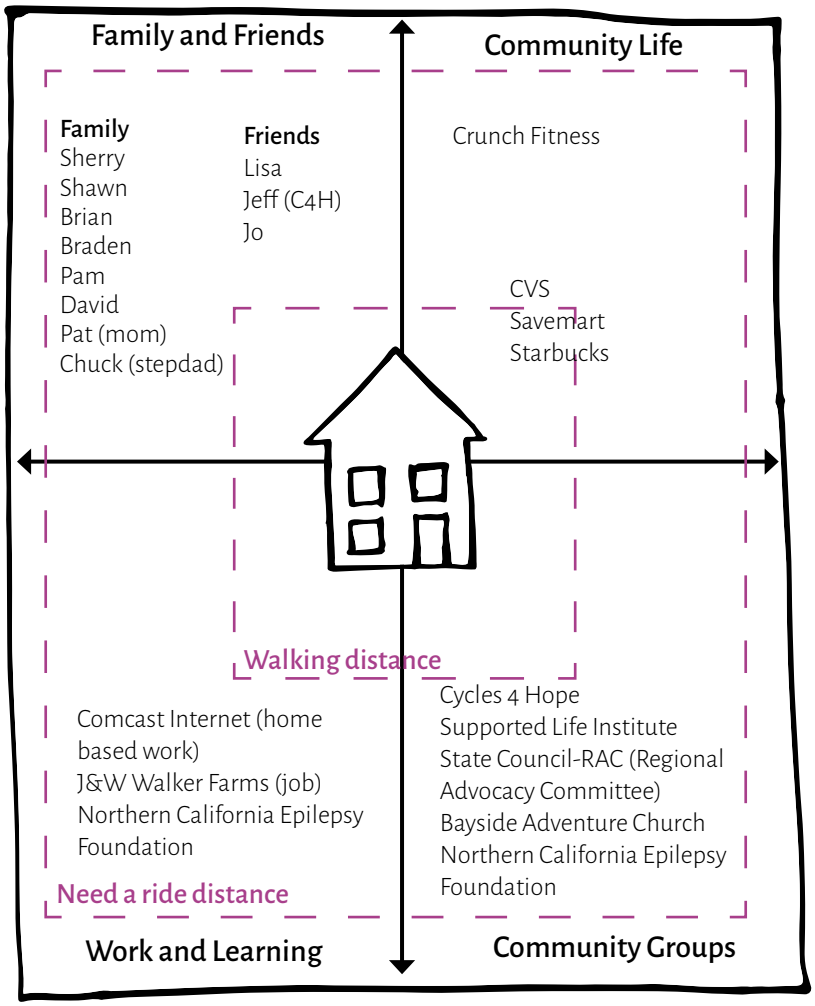
Being Part of the Community

SKILL: Community Mapping

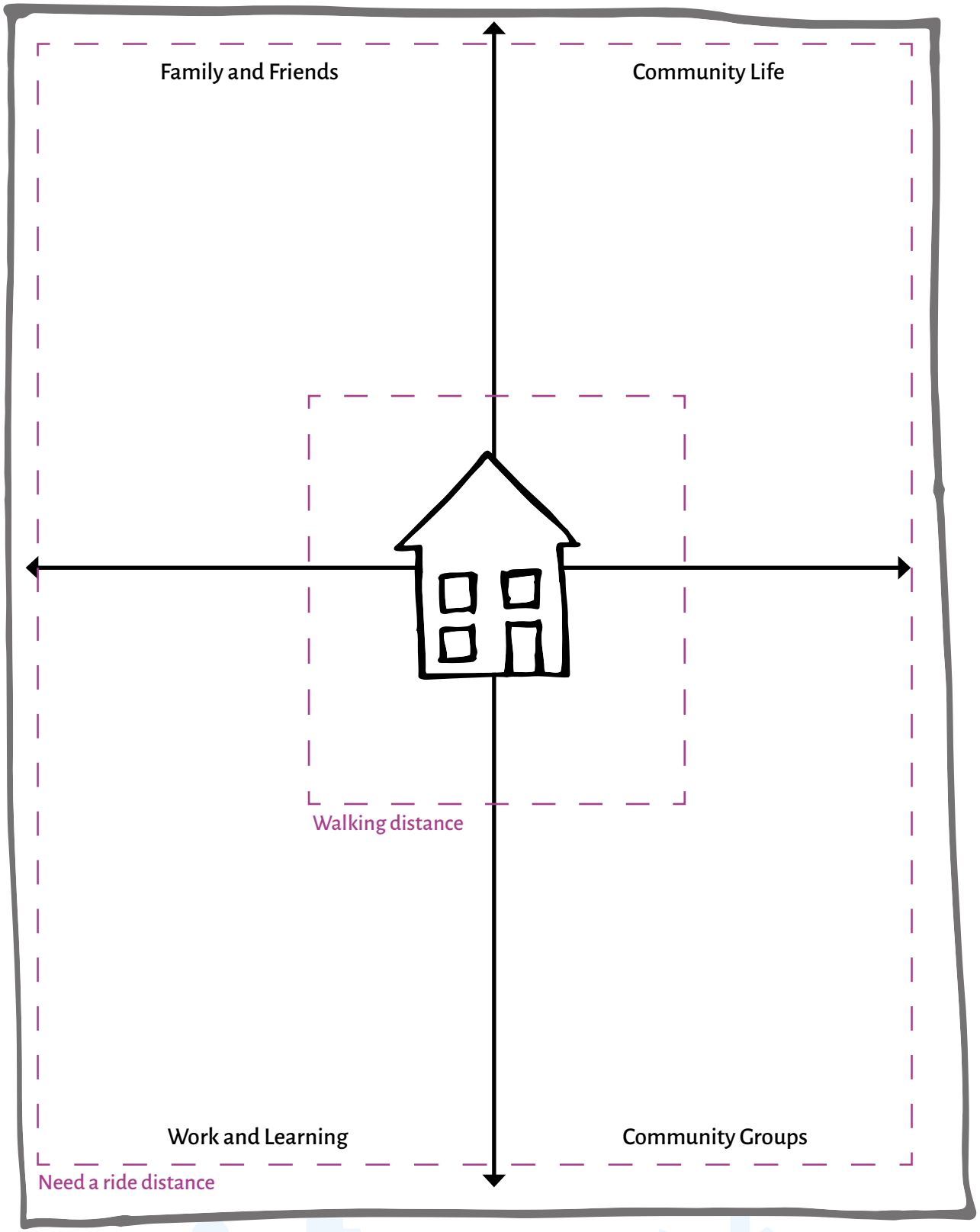
SHARING STORIES

Tyler

Tyler's support staff worked on helping him achieve what is important to him in becoming a valued member of his community. They created a map of his community which captured people and places important to him. The map identifies places he can walk to and places that require transportation.



SKILL: Community Mapping



Being Part of the Community

SKILL: What Happens Here?

HOW TO DO IT

SHARING STORIES

What it does

Helps us to learn about the characteristics, social rules and roles of a group.

How it helps

Identifies things to do to help the person fit in. It looks at what happens in different stages of interaction.

How to use it

Consider an activity that a person wishes to try out. Make a list of "need to know" information.

Ask questions that might include:

- What time do people arrive?
- How are they dressed?
- Do they take anything along?
- Are there any unwritten rules?
- Where do people sit?
- Do people have roles?
- Are there any individual or collective expectations?
- How do people leave?

Tyler

One of the things important to Tyler is using his gifts to be able to help others. He has the knowledge and ability to repair a variety of things. Staff have identified Cycles 4 Hope as a place in his community where he might enjoy sharing his skills. Tyler and his staff prepared the following "What Happens Here" analysis to help ensure Tyson has the information and support he needs to become a valued participant.

SKILL: What Happens Here?

What Happens Here?

Cycles 4 Hope

What time do people arrive?
6-9 p.m. Wed. and Thurs. Tyler goes on Wed.
It is only open six hours per week (Wed. and Thurs. 6-9 p.m.)

How are they dressed? Wear your Cycles 4 Hope t-shirt or your volunteer group t-shirt. Put on an apron; you will get greasy and dirty.	**Do they take anything along?** Bring a good attitude, willingness to learn and desire to help.
Are there any unwritten rules? Make sure all tools are put away at the end of your shift. Clean up after yourself. When stripping your bike, it is good to save all parts in case they can be reused. Ask anyone for help, we are a friendly bunch.	**Where do people sit?** If it is busy, they can still accommodate you. You might choose to work outside.
Do people have roles? Take your bike to a QA mechanic (Jeff, Ed). Have a snack if someone brought one—cookies seem to be a favorite (you may want to bring some to share)!	**Are there any individual or collective expectations?** The program is free. Cycles 4 Hope works on donations (you might want to donate a bike or supplies).
How do people leave? Help others finish. Tyler and his staff stay and help clean up the shop (sweep, make sure all tools are put away).	**How do we make introductions?** Keep an ear open for anyone that needs help, especially new volunteers. When your bike is done, some people leave, others work with someone else to help them finish.
What would it take to make connections within this group? Check in about the events that are upcoming so you have the info needed to participate. Leave with a joke and farewell: "See ya next week!"	**What does good support for the individual you are supporting look like?** If Tyler has a seizure make sure he is not injured; give him a few minutes and he will return to his task.
What does "over-support" look like? When you are supporting Tyler at Cycles 4 Hope, give him space; don't just follow him around. Don't hover over Tyler. He does not want to be stigmatized.	**What resources or equipment are needed?** You can bring your own bike tools, or borrow theirs.

SKILL: What Happens Here?

What Happens Here?

What time do people arrive?	
How are they dressed?	Do they take anything along?
Are there any unwritten rules?	Where do people sit?
Do people have roles?	Are there any individual or collective expectations?
How do people leave?	How do we make introductions?
What would it take to make connections within this group?	What does good support for the individual you are supporting look like?
What does "over-support" look like?	What resources or equipment are needed?

HOW TO DO IT

SKILL: Presence to Contribution

What it does

This is a way of having a conversation with someone your team supports, to find ways to enable the person to be part of their community.

It enables you to record what the person is interested in (or copy from their one-page profile), what it means to be present for an activity and what they could do to contribute to it more fully.

How it helps

It provides a structure to think about what a person does on a day-to-day basis, so that we can see opportunities for them to make new connections, meet new people and contribute to the community.

How to use it

Identify activities that the person is already involved in, or wishes to be. Decide where on the graphic 'from Presence to Contribution' this is currently located. Then work together to move the activity from present to presence, active participation to connecting, connecting to contribution.

Questions to ask

- Which activities can be regarded as vehicles for developing relationships?
- What might we see happening if the person is truly connecting?
- What might we see happening if the person is making a contribution of investing in community?

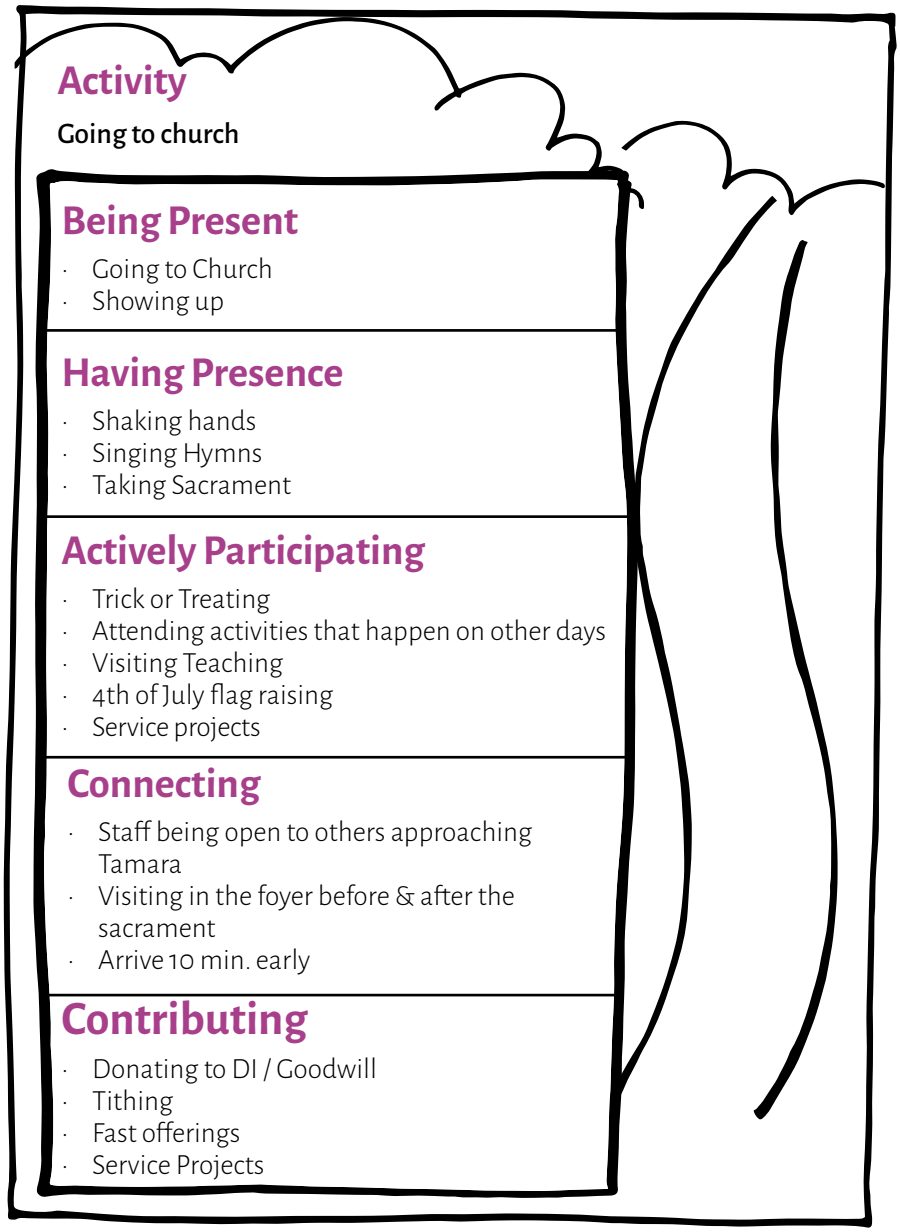
Being Part of the Community

SKILL: Presence to Contribution

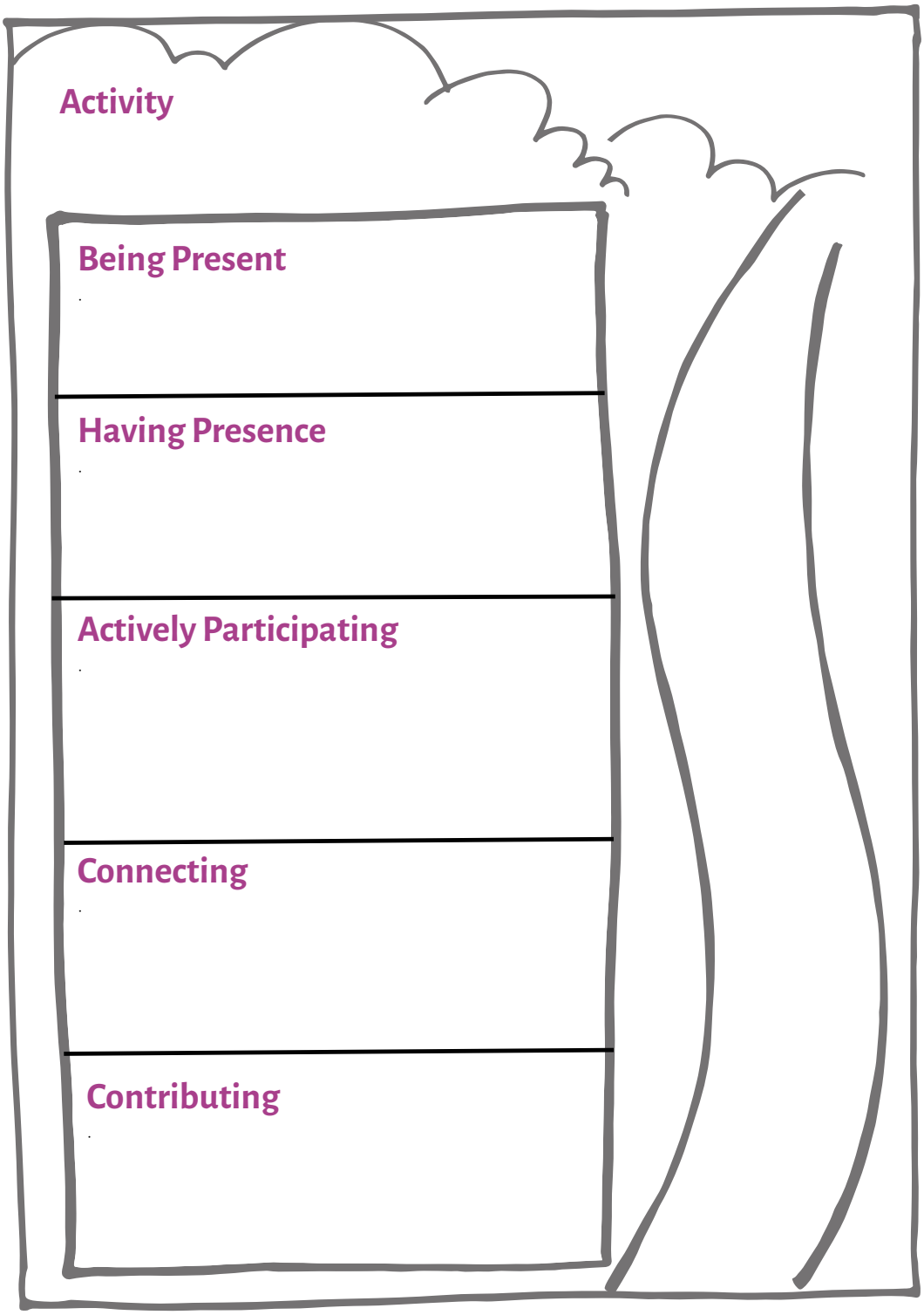
SHARING STORIES

Tamara

Our community mapping identified church as a place in the community where Tamara had some connection. For a long time, Tamara came to church late, often leaving before the services were over. As she got more and more comfortable at church, her support staff decided to use the Presence to Contribution tool to look for ways Tamara could become a valued member of her church community. Her team has done a fabulous job of focusing on ways to go from Presence to Contribution at church. These efforts have brought many fabulous experiences for Tamara, her support staff and church community.



SKILL: Presence to Contribution



*Used with permission from Helen Sanderson Associates

Choosing Where and How to Live

Quality Requirement #2: Choice

This means that the setting supports a person with a disability to choose where and how they live from among options that include settings where people without disabilities live and spend their day. For residential settings, this includes having an option for a private room when available.

How are you doing?

Did the person choose where they live?	Yes	No
Did the person choose who they live with?	Yes	No

If answered "no," what changes should be made so that people have choice?

Person-centered thinking tools and practices that can help

Featured examples to achieve quality in this area

- Decision-Making Profile
- Decision-Making Agreement

Other skills that can be useful in gathering and documenting information

- Important to / Important for
- Matching
- Routines & Rituals
- Good Day / Bad Day
- Working / Not Working

HOW TO DO IT

SKILL: Decision-Making Profile

What it does

The decision-making profile creates a clear picture about how a person makes a decision and how they want to be supported in decision-making. It can be used alongside the decision-making agreement to help people to have choice and control in their lives.

It describes how to provide information in a way that makes sense to that person. This could be how they want you to structure your language, whether they want written words, symbols or pictures, or perhaps an audio format

How it helps

The sections of a decision-making profile help us to support a person to understand choices that are available to them and make informed decisions. This is invaluable when thinking about consent and capacity.

How to use it

Gather information from the person and those they know well to complete five sections of the decision-making process:

1. How I like to get information.
2. How to present choices to me.
3. Ways you can help me understand.
4. When is the best time for me to make decisions?
5. When is a bad time for me to make decisions?

When you are completing a decision-making profile with a person look at their one-page profile and communication chart. See what these tell you about the best times and ways to support the person to make a decision.

It might help to think about a decision the person has had to make in the past and then think about what worked and what did not work for them about how they were supported.

SKILL: Decision-Making Profile

SHARING STORIES

Angie

Angie has a vibrant personality and can clearly let you know what she likes and doesn't like. She lives with three other women and she has direct support to help her throughout her day. Angie doesn't use a lot of words to communicate and relies on her actions to let others know how she is feeling. When Angie feels out of control of the things happening around her, like how she wants to spend her day, she might yell, throw things, or hit people to let you know she is frustrated.

The staff where Angie lives helped her to complete a decision-making profile and a decision-making agreement. Staff learned how to support Angie in making decisions and how to make sure she has control over important decisions in her life.

When Angie has more choice and control in her life, she doesn't yell, throw things, or hit others and is more likely to share her vibrant, cheerful disposition!

How Angie likes to get information.	How to present choices to Angie.	Ways you can help Angie understand.	When is the best time for Angie to make decisions?	When is a bad time for Angie to make a decision?
From favorite staff. Pointing. Photographs (line drawings don't work). Some signs.	Have staff who are a good match with Angie offer her a limited number of choices by pointing, showing photos or using signs she knows well. Be patient, give her time to process and make choices.	Be clear about time frame. Are you talking about now, or tomorrow? Show her the calendar.	One-on-One conversation. When things are quiet and calm. When Angie is not distracted by other activities.	When Angie is agitated. When her environment is chaotic and noisy. When other distracting activities are happening around her. When "Barney" is on TV.

SKILL: Decision-Making Profile

How I like to get information.	How to present choices to me.	Ways you can help me understand.	When is the best time for me to make decisions?	When is a bad time for me to make a decision?

SKILL: Decision-Making Agreement

SHARING STORIES

Angie

Angie's Decision-Making Agreement is based on what was learned from her Decision- Making Profile.

Angie created a decision-making agreement based on what she shared in her decision-making profile. To support her in implementing her agreement, staff created a set of wallet size photos of people, friends and things that were important to Angie. Photos included pictures of family (staff would assist her in calling them), the doctor's office (to prepare for visits), her staff (when possible she could choose who to work with), and many of her favorite things including her stuffed animals and Barney. Having these photos facilitated Angie making choices about what she wanted to do in her day and with whom she wanted to spend time. Having that control in her life made it much easier for Angie to go about her day without yelling or harming herself or other, which is what she would often do when people were not listening to her.

Important decisions in my life…	How must I be involved?	Who makes the final decision?
· Whom do I spend time with (staff, friends)? · What activities do I participate in? · Eating (what, when, where). · Medications - Health Care.	Give Angie a few choices based on what you know is important to her. Point out or show her photos, be clear on the time frame. Use the Calendar. Be prepared to show Angie (pointing – photos) her choices when things are quiet. Know what helps Angie calm herself when needed (Barney video). Angie likes going to the Doctor but you must let her know well in advance. She likes apple sauce with her medications.	Angie.

What would it take for me to have more control of my life?
Be prepared to show Angie (pointing – photos) her choices when things are quiet. Know what helps Angie calm herself when needed (Barney video)

SKILL: Decision-Making Agreement

Important decisions in my life	How must I be involved?	Who makes the final decision?

What would it take for me to have more control of my life?

Having Privacy, Dignity and Respect

Quality Requirement #3: Individual Rights

The setting supports individual rights including privacy, dignity and respect, and freedom from coercion and restraint. Some of the individual rights that a person with a disability has include:

- being able to lock your doors.
- using the phone when you want.
- coming and going as you please.

How are you doing?

Is the individual able to have personal space and time alone when receiving services?	Yes	No
Is the individual able to come and go as they please?	Yes	No
Is the individual able to have visitors where they live and receive services?	Yes	No
Do people listen when the individual speaks up for themselves?	Yes	No

If answered "no," what changes should be made so that people have choice?

Person-centered thinking tools and practices that can help

Featured examples to achieve quality in this area

- Communications Tools
- Routines and Rituals
- Good Day / Bad Day

Other skills that can be useful in gathering and documenting information

- Important to / Important for
- Decision-Making Profile
- Decision-Making Agreement

HOW TO DO IT

SKILL: Communication Chart

Learning, Using and Recording Communication

What it does

The communication chart is a simple but powerful way to record how someone communicates with words and with behavior.

This tool helps us to focus on what someone is trying to communicate, whether they use words or not. It is also useful when the ways that people communicate with their behavior are clearer than the words that they use, or when what people say and what they mean are different.

How it helps

It is easy to assume that someone doesn't have much to say if they rarely speak, but it isn't the case. Everyone communicates. This person-centered thinking tool helps us to find other ways of communicating well together

A communication chart ensures that people are understood. This is so important, especially for people who rely on others for support. Having the power to communicate and be understood is central to people having choice and control in their lives.

How to use it

As you start to build the communication chart, look for easy, simple, and clear expressions.

- How do you know if the person is happy, sad or angry?
- How do you know if the person likes or dislikes something?

It helps to start as soon as an opportunity presents itself and continue to update the chart as new insights are gained.

Make it available, both to those who are new in the person's life, and, as communication changes or becomes more complex, those who have experiences and learning that should be added.

1. Start with what you see or hear the person saying or doing.
2. Notice what is happening in the environment.
3. Write what you think it means; what you think the person is trying to communicate.
4. Write what others should know or do in response to what was communicated.

Having Privacy, Dignity and Respect

SKILL: Communication Chart

SHARING STORIES

Lionel

Lionel lives in a home with three other men. He's popular at home because he's got great computer skills and loves to bake! Lionel decides he is going to Google a recipe for pumpkin muffins. He plans to bake a batch to share with his friends at home. After making a shopping list, he and his housemates, accompanied by staff, go to the grocery store to shop for the necessary ingredients to make muffins. Sometimes Lionel uses words to communicate, and other times he uses sounds and gestures to express what he wants and needs. His staff used this experience to add to Lionel's communication chart.

Future staff supporting Lionel will have a much better idea of how to provide good support to Lionel based on their access to his Communication Chart.

Note: Staff used the third person in this communication chart because they were filling this out on Lionel's behalf as the ones who know him best.

What's happening (or has just happened)…	Lionel does this…	We think it means…	And others should…
Lionel is in the den on the computer, searching the internet for pumpkin muffins recipes.	Furrows his brows and grunts loudly.	He's focusing intently.	Don't interrupt him—this interferes with his concentration. Wait for him to request assistance if needed.
Lionel is at the grocery store searching for flour.	Open handed, slaps his own face with force and loudly grunts.	He is frustrated that he can't find the flour.	Encourage Lionel to use a helpful coping skill (i.e. deep breaths). In order to encourage more autonomy, ask Lionel if he sees any aisle signs that will tell him where to find baking ingredients.
Lionel is at in the kitchen preparing the wet ingredients for his pumpkin muffins.	Rubs his hands together repeatedly.	He's unsure of the next step in the process of what he is planning to do.	Wait a few minutes to see if he is able to get back on task. If not, ask Lionel how he is doing.
Lionel is in the living room handing out the pumpkin muffins to his friends.	Loudly repeats a line from his favorite movie "'What ain't no country I ever heard of! They speak English in 'What?'"	He's experiencing a less than enthusiastic response from his friends and feels disappointed and is starting to get angry.	Ask Lionel if there's anyone else he'd like to give some muffins to. Ask if he'd like to bring some to the neighbor.

SKILL: Communication Chart

What's happening (or has just happened)…	..... does this…	We think it means…	And others should…

Having Privacy, Dignity and Respect

SKILL: Routines and Rituals

HOW TO DO IT

What it does

A reminder that routines and rituals help others understand what matters to a person and what helps them to have good days. It looks at a variety of situations around which we often have personal routines and rituals.

How it helps

Understanding someone's routines and rituals is essential to providing quality person-centered support. Learning about the cultural traditions and rituals of someone you support is key to providing culturally appropriate supports.

How to use it

You can learn about these routines and rituals through conversation and observation of the individual you are supporting, as well as through conversations with those that know the individual well (consult your Relationship Map). Think about others who support you as well as the people you support. How important would it be to know the following?

Morning
Wake up to what (alarm, clock radio, multiple reminders, allow snooze alarm)? How much time is needed to get out the door? What is the morning hygiene routine? Are there any special products used? Pick out clothes the night before? Morning of? What are favorite breakfast foods? Is caffeine delivery required? If so, what type?

Bedtime
Do you need to check the door and windows before you go to bed?

Mealtimes
Do you eat dinner at the same time every Sunday? Do you have a particular way to set the table?

Transition
Do you have to organize your day before it starts?

Birthday
Should it be a "national holiday?" Do you hope that no one notices?

Cultural/Holiday Traditions
What is your favorite holiday? What food has to be on the table for it to be that holiday?

Not feeling well
How do you cope with not feeling well? Are you like a cave bear hiding when you are ill? Do you say leave me alone, or throw food in once in a while? Do you want to be taken care of, or want to be babied?

Spiritual
Are religious services, prayer, or meditation important?

Vacation
Are there things that need to be present in order for it to be a real vacation? When does it start—talking and planning in advance, or not until it actually begins?

Comfort
What helps you feel better when you are having a bad day? Would you find... exercise. . . shopping. . . chocolate. . . a drink. . . or something else comforting? Would you find cleaning comforting, or would you find it punishment?

Celebration
What do you enjoy or need to have happen to feel that you have celebrated?

Grief/Loss
What are the myriad rituals for coping with grief and loss? Methodist upbringing—service in the church sanctuary, luncheon in the church basement? Someone who is Catholic—sitting up late tell stories and have an adult beverage (or many)? Might it be Jewish--sitting Shiva for 7 days? Or other rituals like -cover the mirrors. . . stop the clock. . . bring comfort food when they visit. . . parade of callers. . . 24 hour candle light at anniversary of someone's death.

SHARING STORIES

SKILL: Routines and Rituals

Juan

Juan has just moved to a new home where he lives with three other men. He likes the people at his new home and seems to be getting along well.

Then comes Christmas Eve. Everyone is excited; they go together to the beautiful ritual of Christmas midnight mass. Juan appears to enjoy the music and pageantry. On returning home from church, the staff tells Juan it is time to go to bed and get a good night's sleep. That way, he is ready for the big Christmas Day feast and celebration the next day. They are shocked by his reaction. Juan gets very upset; yelling, screaming and breaking Christmas decorations. He insists he will not go to bed. Staff are mystified—until they belatedly check with his family and the staff from his previous home. It seems that in Juan's home growing up, as well as in his most recent home, a different Christmas tradition was followed. His family, and later his housemates, would attend midnight mass then return home to enjoy a big celebration, presents and feasting. In his new home the men would attend midnight mass, come home and go to sleep, in anticipation of a party with presents and feasting at noon on Christmas Day.

This being an unfamiliar ritual, Juan thought he was being sent to bed and would not be allowed to participate in the festivities he expected upon returning from church. Recovering from the emotional trauma and rebuilding Juan's trust in the people at his new home took a lot of time and effort that could have been avoided by a little research into his important routines and rituals.

Use the Relationship Map to identify whom in addition to the individual you are supporting to interview about their Routines and Rituals. Be sure to record what you have learned so you can share it with others.

Having Privacy, Dignity and Respect

SKILL: Routines and Rituals

Morning	Not feeling well
Bedtime	Spiritual
Mealtimes	Vacation
Transition	Comfort
Birthday	Celebration
Cultural/Holiday Traditions	Grief/Loss

HOW TO DO IT

SKILL: Learning Log

We never stop learning about the people we support. As new discoveries are made about what matters to a person, from their communication chart or routines and rituals, or from conversations about what makes a good day and a bad day, it's important to write down what is learned and share it with others who are also supporting that person.

Notes and files that are kept by people in support roles often record the facts about what is happening day-to-day, but not what we is learned. When supporting others, it is important to capture any learning as it happens, because this can be used to inform planning and shape the support that is given.

What it does

The Learning Log offers a process to record what a staff member is learning while supporting someone.

- It is most useful when people are trying out new activities or are being supported by a new team member.

How it helps

- By capturing this information and reviewing it, the whole team can keep learning how to give the best support.
- Learning Logs should be reviewed regularly by team leaders and shared with the people involved in the support.

How to use it

The Learning Log is organized to reflect on an activity or new set of circumstances using the following questions.

- Date
- What did the person do? (what, where, when, how long, etc.)
- Who was there?
- What did you learn about a strategy that worked well? What did the person like? What needs to stay the same?
- What did you learn about a strategy that did not work well? What did the person not like? What needs to change?

Review new insights with the broader team to figure out how support can evolve to build upon what is working and change what's not working.

Having Privacy, Dignity and Respect

SKILL: Learning Log

SHARING STORIES

Lucas

Lucas is has lived in a small residential home setting for the last 10 years. Lucas' life is currently going well. He has developed new ways to communicate. Lucas used to use mostly gestures, facial and vocal expressions, and now he also uses short sentences to express how he feels.

Although Lucas likes new places and people, sometimes he is uncomfortable in places with a lot of traffic, sound, and crowds. If it's a good day Lucas is willing to try almost anything. If the day has been challenging, his support staff need to get a little more creative to provide good support. Lucas loves trying new lunch places. He's a foodie, and eating gives him great joy. He particularly likes crunchy foods like chips, corn nuts, and all types of crunchy, fresh veggies. Lucas has recently been supported by Maggie, a support professional at his home. Maggie recorded the information below on several lunch outings with Lucas.

Now, even if Maggie is not available to take Lucas out to lunch, other staff will have good information on how to provide quality support. Lucas and his support staff are much more likely to have a great time going out for lunch.

Date	What did the person do (what, where, when, how long etc.)?	Who was there (staff, friends, others, etc.)?	What did you learn about a strategy that went well? What did the person like about the activity? What needs to stay the same?	What did you learn about a strategy that did not work well? What did the person not like about the activity? What needs to be different?
02/01/19	Lucas and Maggie went out for lunch to North China Restaurant for 1.5hrs.	Lucas and Maggie.	North China has an aquarium with lots of fish, coral etc. near the booths. Lucas smiled the whole time they were there, and he stared at the fish often. He likes green beans, and he was happy the restaurant had many dishes with them.	Lucas did not eat much during this trip, which is extremely out of character for him. We took his lunch home.
04/18/19	Lucas and Maggie out for lunch to North China Restaurant 1.5hrs.	Lucas and Maggie.	Our favorite booth we like to sit at was available. While there, Lucas enjoyed telling me about his love of fish.	We were there during the lunch rush which appeared to make Lucas uncomfortable. He was flapping his hands often and became very quiet. He picked at his green bean dish and we ended up taking it home. We should avoid lunch rush next time.
05/03/19	Lucas and Maggie out for lunch to North China Restaurant 1.5hrs.	Lucas and Maggie.	Lucas was so happy to see the restaurant now has a frog in the aquarium. Also, we got our favorite booth nearest the aquarium. We arrived in the early afternoon, after the lunch rush.	Lucas only picked at his food today. Before we left, he actually told me, "Chinese food is yuck," and that he wishes he had an aquarium at home. Next time, we will talk some more about a menu for wherever we're considering eating, and also about what it would take to get him a fish tank at home.

SKILL: Learning Log

Date	What did the person do (what, where, when, how long etc.)?	Who was there (staff, friends, others, etc.)?	What did you learn about a strategy that went well? What did the person like about the activity? What needs to stay the same?	What did you learn about a strategy that did not work well? What did the person not like about the activity? What needs to be different?

Independence

How and With Whom I Spend My Time

Quality Requirement #4: Independence

The Independence means the individual is in charge of making decisions about their life and what they want to do. These decisions include their daily activities, their surroundings, and the people they interact with. Some examples of independence include when people are:

- Setting their own schedule.
- Choosing where they want to go.
- Controlling their own budget.

How are you doing?

Are they able to choose their own schedule?	Yes	No
Do people choose what they do for fun?	Yes	No
Do people choose how to spend their money?	Yes	No
Do people have a chance to make decisions about their life and what they want to do?	Yes	No

If answered "no," what changes should be made so that people have choice?

Person-centered thinking tools and practices that can help

Featured examples to achieve quality in this area

- Routines and Rituals
- Good Day / Bad Day
- Perfect Week

Other skills that can be useful in gathering and documenting information

- Important to / Important for
- Relationship Map
- Working / Not Working
- Decision-Making Profile
- Decision-Making Agreement

HOW TO DO IT

SKILL: Good Days and Bad Days

What it is

Good Day and Bad Day is a way to learn about what matters to someone and what support they need to have good days and avoid bad days.

How it helps

Through conversations, it helps us learn what contributes to a typical day, what can make it a better day and what can make it a worse day.

It helps gather information about what is important to and important for someone related to their independence.

We need this information about everyone who receives support, and colleagues as well. This is a way to start or add to one-page profiles for colleagues and for those supported, and to decide together on actions.

Adhira's example was completed for work. It started with what might be a typical day—what usually happens—and then looked at what makes it a better or worse day. We looked at the entire day because many people have had things that happen before they get to work/school, that impacts how your day goes. And what about the end of the day and the impact it has on you?

How to use it

It helps to look at something specific for the good or bad day. What makes a Good/Bad day at home? At work? Weekend? With friends?

Start with getting up or whatever the person does to get ready to leave for work.

Do not write down any fantasies.

Make a composite of the worst days the person has had.

Leave space between the lines so that others can add what they know of the person's worst day/workday.

Record activities in the order they occur. Focus on the person's entire day or a portion of it: morning routine, work day, after work until bedtime, etc.

Only share what the person is comfortable sharing.

Use the Good/Bad Day chart to begin to understand what is important to that person. Begin to ask each other what we can do to help this person have more good days.

Remember: The person is the expert and has the final word. Consult with him/her during the exercise as much as possible and in setting goals at the end of this exercise.

Independence

SKILL: Good Days and Bad Days

SHARING STORIES

Adhira

Adhira is witty and clever, and she loves to visit with family, friends and colleagues over a cup of coffee. Adhira's parents are the most important people in her life; she takes advantage of any opportunity to spend time with them. Adhira has impeccable comedic timing and tries to find humor in some of her own challenges as well as the challenges of others. She knows what she wants and how to get it, and she doesn't have much patience for people who insult her intelligence. She is very capable of making her own decisions and doesn't appreciate it when others try to take away her independence. Adhira lives with three other women in a specialized group home and attends a day program.

Nothing annoys Adhira more than when she has to tell her direct support staff the same thing over and over again. For example, she'd rather wear a hat than sunblock because she hates the smell, but she finds sunblock in her backpack rather than the hat. Fruits and veggies for lunch are fine, but please no carrots because they hurt her teeth (two days out of five she finds only carrots in the fridge to pack for lunch). Repeatedly ignoring Adhira's likes and dislikes leads to frustration. Sometimes she throws things. Her support staff captured some of what they learned in the Good Day / Bad Day table. Having new staff oriented to this information greatly reduced Adhira's level of frustration and helped her to have more good days. And when Adhira is happy, her staff is happier too!

Time of Day	Typical	Better	Worse
Morning at Home	I get ready for the day, eat breakfast and have coffee.	Pancakes and eggs for breakfast, and time for at least two cups of coffee.	Cereal for breakfast. I'm rushed, so no time for coffee and only carrots to pack for lunch.
Commute	Van ride to program.	My mom and dad pick me up, drive through Starbuck's then drop me at program. Staff packed my hat.	Van is late, other passengers are in a bad mood and hitting people, staff are on their cell phones, staff packed sunblock.
Morning	I meet my staff worker for the day and we discuss the day's activities.	I'm assigned my favorite staff member and we plan to be out the entire day at Adopt a Park.	I'm assigned a new staff member who I don't know, and who doesn't know me. They are new, so they don't want to go anywhere.
Lunch	Eat sack lunch I helped prepare from home.	McDonald's with my mom and dad.	Turkey sandwich with cheese (I hate cheese!), no chips, and water!

SKILL: Good Days and Bad Days

Time of Day	Typical	Better	Worse
Morning at Home			
Commute			
Morning			
Lunch			
Afternoon			
Commute			
Evening			
Overnight			

Independence

SKILL: Perfect Week

HOW TO DO IT

What it is

A perfect week describes a person's ideal week, which is both practical and possible within resources (e.g. personal strengths, assistive technology, friends, neighbors and family, community-based organizations, self-determination Individual Budget, and other eligibility-based supports)

It is a detailed description of how a person wants to live, not an unrealistic dream. It includes the important places, interests and people that matter to a person.

How it helps

The perfect week can become the basis of a personalized schedule, and you can use the matching support process to think with the person about who they want to support them for each element of their perfect week.

How to use it

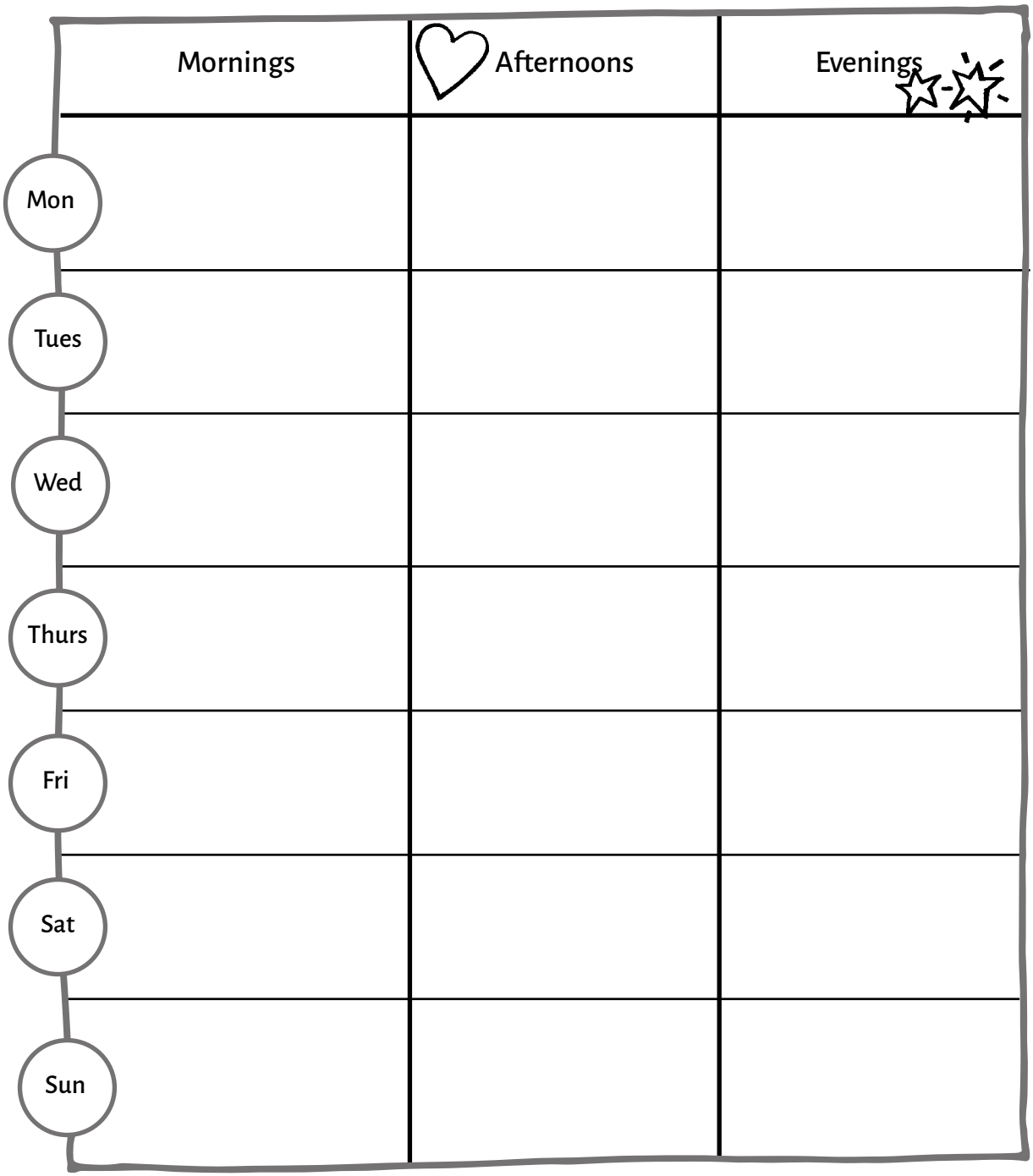
Using the perfect week tool helps people to think about what they would like their life to look like, and can form the basis of an effective person-centered care and support plan. It can also be used to make sure that people are not overprotected or over supported and have choice and control wherever possible. This helps people to use paid support in the most effective way.

Darnell's Perfect Week

Perfect Week

	Mornings	Afternoons	Evenings
Mon	Photography on the river (with Anthony and Terrell) (All day, once a week)	Photography on the river (with Anthony and Terrell) (All day, once a week)	Evening in with Shanice (watching TV and downloading photos)
Tues	Shopping at Albertson's (with Jackie)	Check job postings (paper/internet/ job center) (with Jackie)	Go to the pub with Shanice (every two weeks with Carmine)
Wed	Creating/building photography web-site (with Anthony)	Meet Shanice for lunch in town (every week) Teach photography at the day center, and see friends	Basketball (Every week with Nick, David and Pedro)
Thurs	Volunteering at animal shelter (with Jackie	Volunteering at animal shelter (with Jackie)	Evening in with Shanice – TV, DVD, listen to music
Fri	Morning in. Update music collection. Physical therapy (every week)	Volunteering at the Zoo (with Phillip)	Night out with Shanice and friends. Meal or the pub (every other week)
Sat	Time with Shanice. Whatever we decide to do.	Meet with mom and dad (every week)	See live music (once a month) With uncle Pete or Pedro)
Sun	Go to church (Shanice is a practicing catholic) (with Shanice's mom)	Go to the gym with Shanice (with Anthony)	Night in with Shanice

SKILL: Perfect Week



Choosing Supports and Who Provides Them

Quality Requirement #5: Choosing supports and who provides them

The provider setting supports you to choose your services and who provides them to you. Choice means that a person can choose what services and supports they need. The person can choose who provides those services and where they are provided. Like most things in life, our choices are based on our needs and preferences as well as the options and resources available to us.

How are you doing?

Does the person choose where services are provided? (for example: group home, own home, day program)	Yes	No
Did the person choose the services they receive?	Yes	No
Did the person choose who provides the services?	Yes	No

If answered "no," what changes should be made so that people have choice?

Person-centered thinking tools and practices that can help

Featured examples to achieve quality in this area

- Matching
- Donut

Other skills that can be useful in gathering and documenting information

- Decision-Making Profile
- Decision-Making Agreement
- Important to / Important for

HOW TO DO IT

SKILL: Matching

What it does

Getting a good match between the person supporting and the person being supported - whether paid or unpaid - is crucial.

The matching support tool is a simple way to record what is needed to create the best match.

How it helps

There are three reasons why every effort should be made to determine what a good match looks like, and why every effort should be made to act on the information.

A good match is:

- One of the most powerful determinants of quality of life for people dependent on others for support.
- The single greatest determinant of turnover among those paid to provide services.
- Related to the incidence of abuse and neglect — the better the match the fewer issues of abuse and neglect.
- Related to staff turnover — where there is a good match between a person needing support and existing staff, or when recruiting new staff there is less turnover.

When agencies look at skills needed to support someone, they typically limit themselves to the skills needed to address issues of health and safety and the general skills needed for the position. It is equally important to address the skills needed for someone to have what is important to them as well as what is important for them. While having the right skills is a minimum expectation, the match regarding personal characteristics is critical.

How to use it

Supports wanted/ needed

List here:

What supports do you need?

What do you need others to do for you, to support you in living the life you choose and being a valued member of your community?

Skills required

List here:

What skills must the person we recruit have?

Include those skills that must be taught and the recruits must agree to learn.

Personality characteristics needed (and to avoid)…

List here:

What are the characteristics of the people in your life who have the best relationship with you?

What characteristics do you think will best match you? What will be the purpose of the person who will serve in your recover?

"Patience is a personality characteristic."

Shared common interests…

List here:

What interests do you want the person we recruit to share (have in common with you)?

Think about things you enjoy that, if better supported, could help you have a more fulfilling life, or make your recovery easier to bear.

SKILL: Matching

SHARING STORIES

Steve

Steve treasures his independence and being able to make his own decisions. He enjoys driving his own vehicle (preferably a truck or van) but can only afford a fixer upper. He likes watching old westerns. His mom and step-dad live locally and he has few other friends. He finds new social settings stressful. He struggles to live within his budget, particularly when he overspends on lottery scratchers.

Steve enjoys buying and selling at yard sales and flea markets. His old truck is frequently breaking down; he needs a working vehicle to continue this work. His purchases frequently clutter up his small apartment to the point that the space becomes unlivable.

Routine is very important to Steve. There are a few things he likes to eat, many of which he should avoid because of his diabetes. Steve is being treated with medications for diabetes, depression, anxiety disorder and OCD. He hates having to take the medications, because they leave him feeling sluggish and even more depressed.

Steve receives supported living services from a local provider. He has hired and fired multiple providers and provider agencies in the last few years. His supported living staff are often half his age, but he sees them as trying to take on the role of his parent, telling him what to do instead of helping him get things done. This rapid turnover in staff and the feeling like he's not being heard has contributed to Steve's declining health, His depression has worsened to the point he has considered suicide.

A new provider agency decided to figure out who would be a good match for Steve. They worked with Steve to interview candidates and selected Jose, a support worker who was Steve's age, someone who was patient and listened to Steve. Jose shares Steve's interest in repairing old cars and flea market buying and selling. Together, Steve and Jose began work on fixing up his old truck. They were able to build a relationship based on working together on a common goal. They later worked together on trading the truck for a van they could fix up, one that enabled Steve to store his purchases until he resold them. As their relationship grew, Steve worked with Jose on finding solutions to some of his challenges, including cleaning, budgeting and health care. To Steve, it felt like problem solving together, not being told what to do. Steve was able to control his diabetes with diet and exercise. He was able to wean off most of the medications prescribed by his psychiatrist. He started cleaning his apartment and bringing his budget under control. Steve summed up the experience by stating his new staff, Jose, "Saved his life." And Jose has never been happier in a job. He's doing things he loves to do with a great guy, Steve. Both lives enriched by a good match.

Choosing Supports and Who Provides Them

SKILL: Matching

Supports Wanted/ Needed

- Support with making healthy lifestyle decisions (foods, medications).
- Support maintaining a clean, uncluttered home.
- Support to learn how manage a budget.

Skills Required

- Patience.
- Understanding of health care needs (diabetes management).

Personality Characteristics Needed (and to avoid)

- Good listener (listen to both my words and my actions).
- Avoid (bossy, parental attitude, dismissive, know-it-all).

Shared Common Interests (* indicates important shared interests)

- Maintaining old cars.*
- Watching vintage westerns.
- Flea market and garage sale shopping.*

Choosing Supports and Who Provides Them

SKILL: Matching

Supports Wanted/ Needed	Skills Required
Personality Characteristics Needed (and to avoid)	Shared Common Interests (* indicates important shared interests)

HOW TO DO IT

SKILL: Donut

What it does

The Donut Sort is a tool that helps staff to see what they must do (core responsibilities), where they can try things (judgment and creativity), and what is not their responsibility, clear expectations about roles and responsibilities are critical to supporting someone well. This tool, referred to as the "Donut Sort" is based on the work of Charles Handy.

How it helps

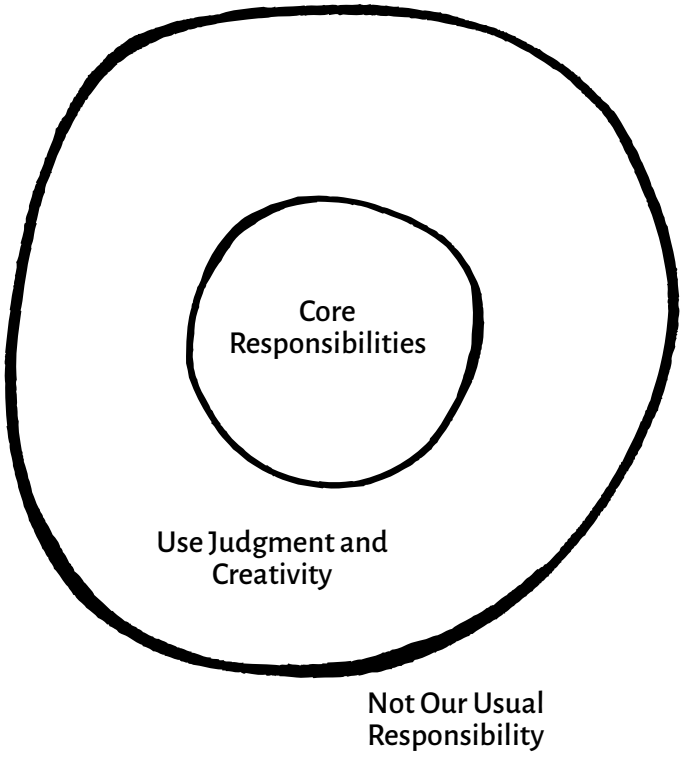
It can help to clarify the roles of the different professionals and agencies involved in supporting someone. This can feed into care and support planning, and can be used to sort roles and expectations in a team plan.

Do a Donut Sort:

- When people do not know their core responsibilities.
- When people do not know where creativity is needed and encouraged.
- When people do not know what is outside their area of responsibility.
- When changes are made in how someone is supported.
- When organizational changes are made that affect roles and responsibilities.

How to use it

1. Start with a specific role in a specific situation.
2. Before you begin the Donut Sort with those you are helping to learn, write down what you know about what is important to and important for the person, and what else you need to learn related to that specific situation.
3. Use the same technique of going from several specific situations to the general when doing a Donut Sort with a manager or a licensed professional.



SKILL: Donut

SHARING STORIES

Dana

Dana is very independent and has made it known that she wants to have a boyfriend. She lives in a specialized community-based residential care setting that supports people who have both an intellectual/developmental disability and a mental health condition. Direct support staff at home learned that Dana, after disappearing from the house overnight on several occasions, had been calling in to a "chat room," where people talked and arranged hook-ups. The residential providers notified Dana and her Service Coordinator of their plan to give her a discharge notice. This was due to the liability she posed to herself, and their inability to meet licensing requirements. When told, Dana was very upset; she did not want to leave.

Her service coordinator suggested to Dana and her team that they meet and use the Donut Sort tool to think in some more depth about the issues before moving to a decision on next steps. The table below shows some of what was learned.

Using the Donut Sort skill allowed the team to work with Dana and develop plans that used creativity around meeting their core responsibilities.

Dana and the staff talked frankly about dating and sexuality. Eventually, Dana still felt that staff were trying to exert too much control over her decisions.

Her team agreed to help her move into a shared apartment, where she could be more independent. She continues to live happily in the community in a shared apartment and independent living supports.

Core Responsibilities	Use Judgment and Creativity	Not Our Usual Responsibility
Adhering to Licensing regulations. Having a plan to keep Dana healthy and safe.	How to support Dana in learning safer ways to meet men and build relationships.	Dana's final choices regarding her relationships.

Choosing Supports and Who Provides Them

SKILL: Donut

Core Responsibilities	Use Judgment and Creativity	Not Our Usual Responsibility

Additional Considerations for Providers

Additional considerations for residential service providers

In addition to the quality requirements, provider-owned or managed residential settings must also ensure that these conditions are met.

Ensuring that people with intellectual/developmental disabilities are provided the protections that are afforded to all California tenants, commonly known as "Tenant's Rights".
A person with a disability must have the same rights and protections from eviction as other tenants. Provisions of this requirement are embedded in the TCRC Placement Agreement.

Ensuring that people you support are treated with respect and are afforded privacy.
Each person will have privacy in his/her room or living unit. Homes shall have entrance doors that are lockable by the person, and only appropriate staff will have keys as needed. People sharing rooms in the home will have a choice of roommates in that setting. People can furnish and decorate their rooms or living spaces within the terms of the lease or other agreement

Supporting people in creating schedules that meet their needs and promote the lives they want to live.
Providers will support people with disabilities to control their day -to-day lives in the same way people without disabilities do. This includes control over when they like to wake up and get ready for the day, as well as when and what to eat.

Ensuring the people have opportunities to have visitors.
People should have the opportunity to develop close, private and personal relationships without unnecessary barriers or obstacles. People with disabilities will be able to have visitors at any time without restriction. Providers should also not screen visitors. This does not mean that people can be inconsiderate of other's rights or the need for quiet and safety in the home. People will be supported to work through these kinds of household agreements as would be expected in any home.

Ensuring that a person's home is accessible to them throughout the day.
Providers will ensure that a person's physical environment meets the person's needs. People must be able to use common areas in the home, such as the kitchen, dining area, laundry area and shared living space, to the extent they desire.

Temporary Modifications – If People Need Extra Support
Sometimes people need extra support and may not be able to take part in all of the freedoms the new rules provide. When that happens, the provider has very strict rules they must follow:

- Base the modification on a specific need;
- Show that positive interventions have been tried, but haven't worked (and document it); Keep measuring if the modification is effective!;
- Show that any modification is TEMPORARY;
- Get informed consent!

In addition to learning what is important to and important for a person, the 4+1 Questions and Person-Centered Approach to Risk, found on the following pages, can help work through and document these kinds of situations.

HOW TO DO IT

SKILL: 4 + 1 Questions

What it does

The 4+1 skill is powerful when used in meetings or reviews, or to look at a particular aspect of someone's life. It can help a service provider look at how to work through issues related to meeting the requirements of home and community-based services.

It can help people to think about a particular challenge or situation and plan for change. Because the 4 plus 1 questions are answered by more than one person, it groups together learning from different perspectives.

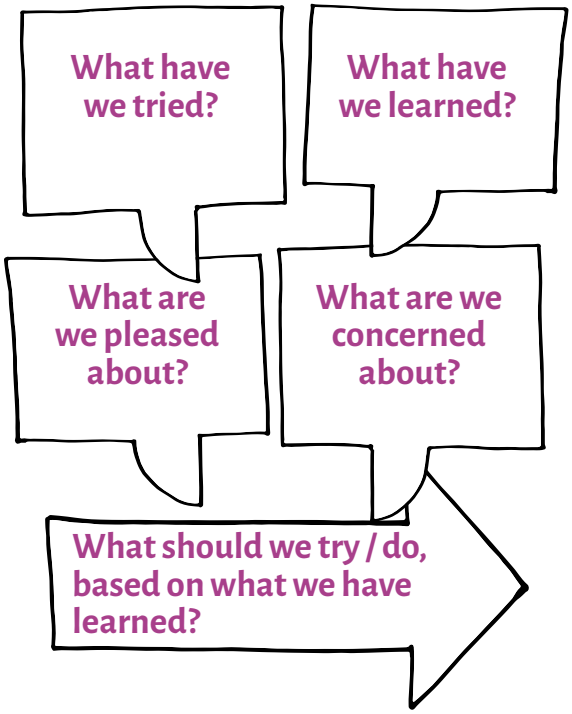
How it helps

It can be used to update a one-page profile or a person-centered plan, or to review a project or plan. It is a quick way to work out better ways of supporting people or working together.

- It prevents a dominant voice" from taking control of the meeting.
- It makes everyone feel that they were listened to.
- It brings forward issues that might have been overlooked.
- When it is time to move forward, the group has a picture of their collective learning to draw on.
- It reinforces planning as a process.

How to use it

Invite everyone to contribute answers to four main questions: What have you tried? What have you learned? What are you pleased about? What are you concerned about? The answers to these questions lead to ideas for the 'plus 1' question – based on what we know, what should we do next?



Additional Considerations for Providers

SKILL: 4 + 1 Questions

SHARING STORIES

Dianne

Dianne, a Service Coordinator, had just been assigned to work with Cathy, who was receiving services through her agency. At her initial meeting with Cathy and the day services support team, Dianne asked Cathy to talk about what was important to her.

Cathy was very pleased to hear the question, enthusiastically sharing her frustration at not having paid work. Dianne noted that as Cathy was speaking about wanting a job, day program staff members rolled their eyes with a "here we go again" expression. Dianne asked about this later in a staff meeting.

She learned that Cathy always talked about wanting a paid job and had been set up repeatedly on paid jobs, each one quickly ending after Cathy refused the work she was assigned.

Dianne suggested that at their next meeting they use the 4 + 1 questions format to examine Cathy's request for paid employment. She encouraged staff members to support each other and Cathy, in considering each of these questions which would be discussed at her next meeting. With respect to finding paid work for Cathy: What has been tried? What has been learned? What are you pleased about? What are you concerned about?

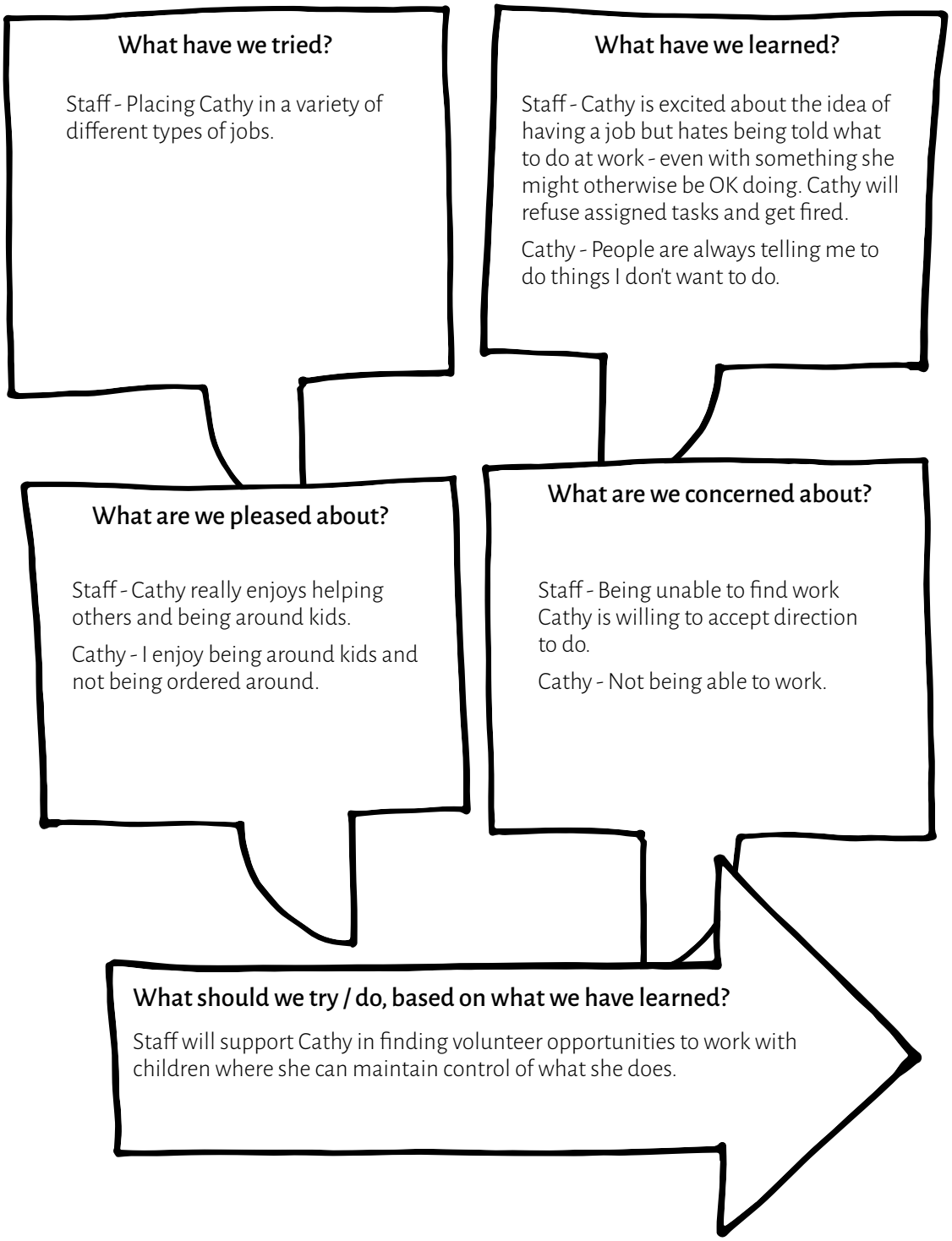
At a follow up meeting, Dianne placed the four questions on the wall and encouraged Cathy (with support) and staff to write their comments on Post-it notes, to be placed on the 4 + 1 chart.

Dianne then facilitated a conversation about what was on the charts.

Following their discussion Cathy and her team agreed a following plan (see next page). The result was, Cathy felt an enhanced her sense of control and responsibility of her life. This allowed her to move beyond her view of herself as a service recipient and to accept more responsibility for choices in her life. Cathy found she loved and was proud of her volunteer work with children.

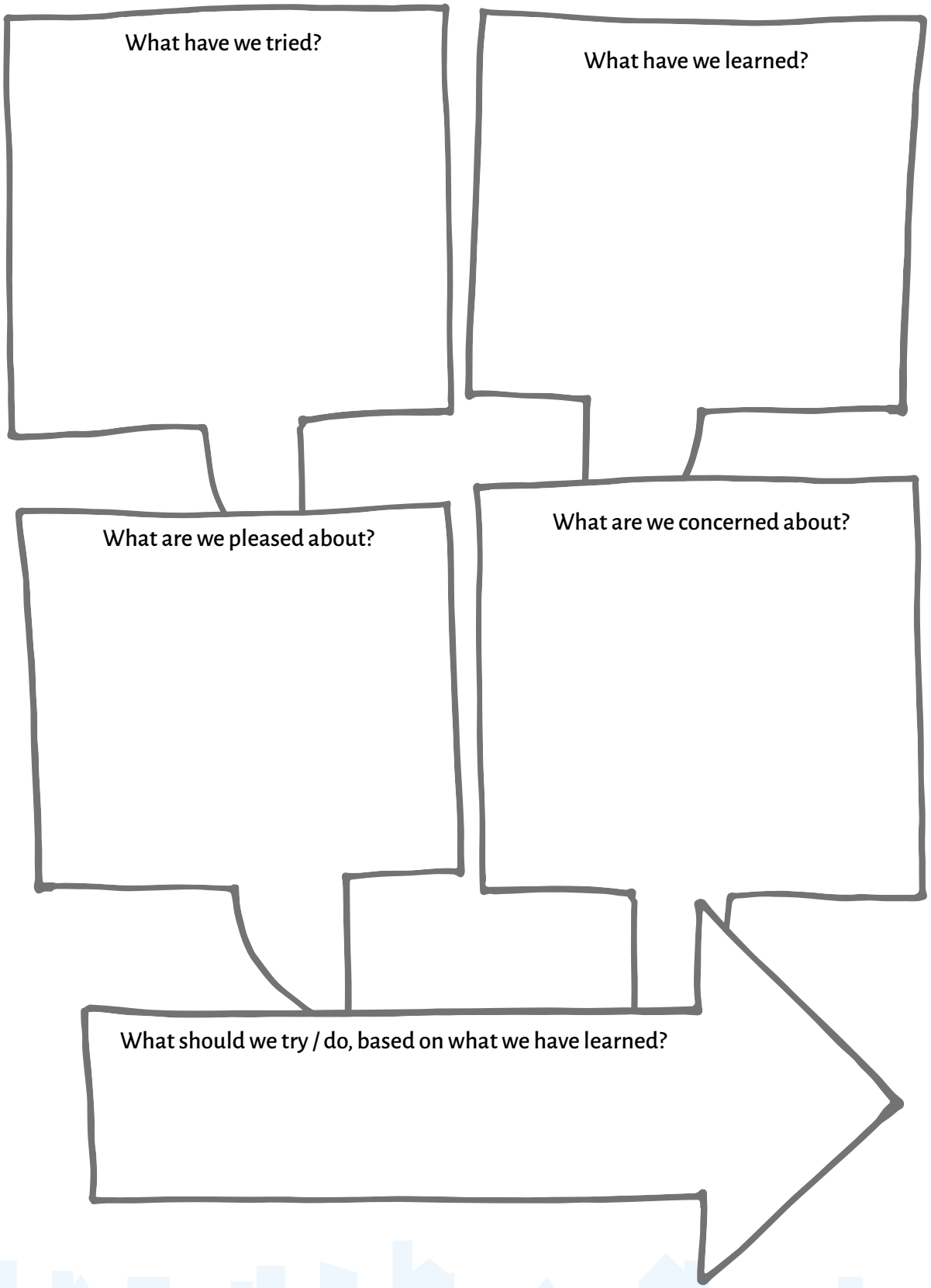
Additional Considerations for Providers

SKILL: 4 + 1 Questions



Additional Considerations for Providers

SKILL: 4 + 1 Questions



HOW TO DO IT

SKILL: Person-Centered Approach to Risk

Choice and Risk

Sometimes, although very well-intended, a service provider and/or service coordinator may limit the choices of a person with a disability because they are worried that the person may be harmed or taken advantage of. Or they might think that the person will make a "bad" choice if given the freedoms required by the HCBS rule.

It is important to remember that all community members, including people who receive home and community-based services, have the right to make choices, even when those choices result in poor outcomes.

People learn by making mistakes. Those in a support role must maximize a person's ability to make choices while minimizing the risk of endangering the person or others.

What it does

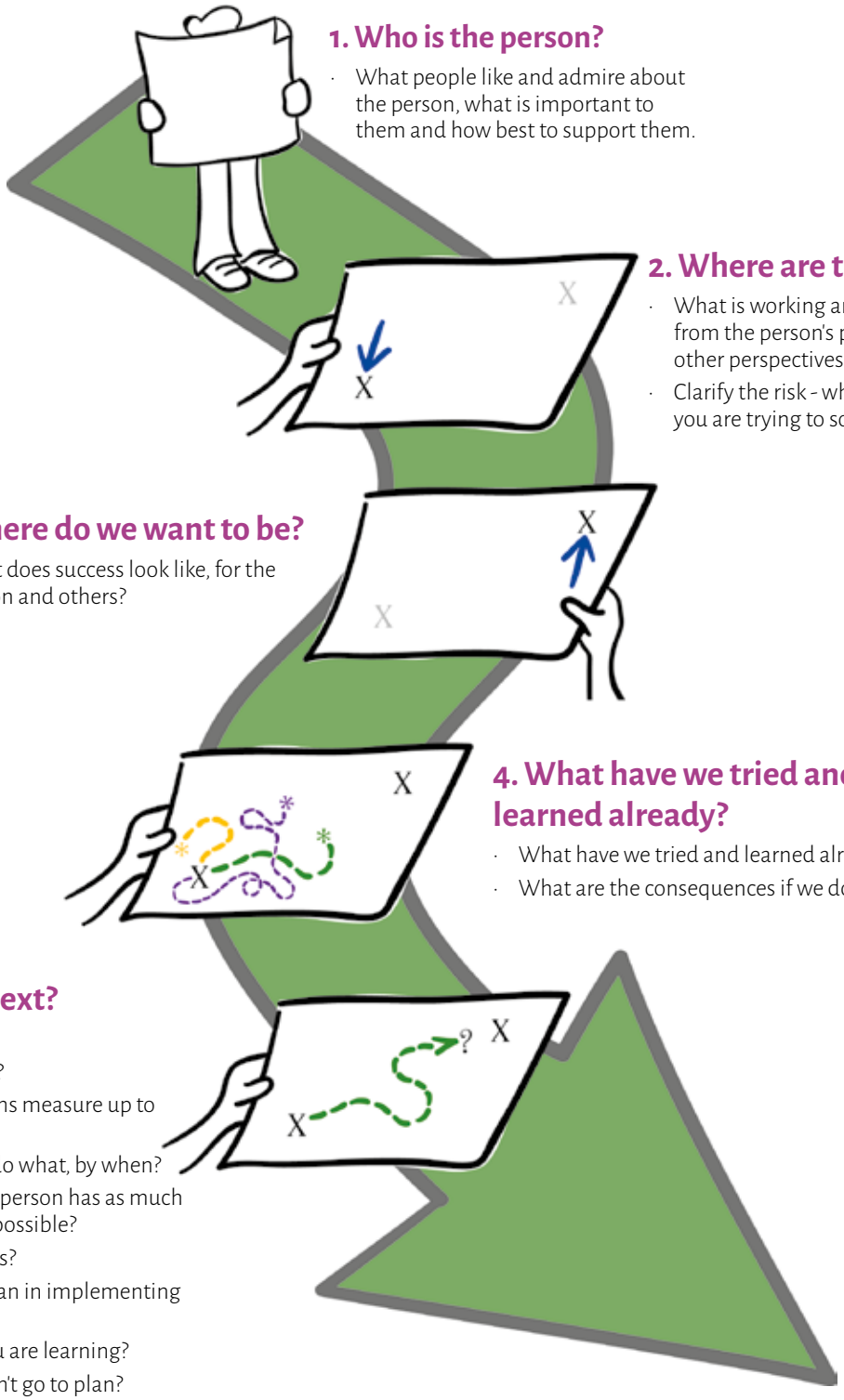
We all take risks – from getting a new job to trying a new hobby, going on vacation or just crossing the road. We evaluate the possible risk and then make a decision based on the potential benefits, while reducing the chance of something bad happening as a result. That's risk assessment. Person-centered risk management is the recognition that people in receipt of support are entitled to take risks to get the life that they want; to take advantage of opportunities even if they come with risk. A life without risk is a life without opportunities, without quality, without change.

How it helps

- Person-centered risk benefits organizations supporting people in all types of care situations – from people who are elderly, or who have dementia, to people with intellectual and developmental disabilities or mental health needs.
- It ensures that risk management starts from the point of view of what makes sense to the person. It is part of how support is delivered, rather than something separate from it.
- It puts the person firmly at the center of the process and starts by finding out what they want from life.
- It enables the person, and their circle of support, to work out how they can achieve what they want as safely as possible – rather than starting by questioning whether it can happen at all, just because they are in receipt of support.

Additional Considerations for Providers

SKILL: Person-Centered Approach to Risk



1. Who is the person?

- What people like and admire about the person, what is important to them and how best to support them.

2. Where are they now?

- What is working and not working from the person's perspective and other perspectives?
- Clarify the risk - what is the problem you are trying to solve?

3. Where do we want to be?

- What does success look like, for the person and others?

4. What have we tried and learned already?

- What have we tried and learned already?
- What are the consequences if we do nothing?

5. What shall we do next?

- What is obvious?
- What are potential solutions?
- How do the potential solutions measure up to what matters to the person?
- What will you try? Who will do what, by when?
- How can you ensure that the person has as much choice and control in this as possible?
- What are your responsibilities?
- What does good support mean in implementing the action plan?
- How will you record what you are learning?
- What can you do if things don't go to plan?

SHARING STORIES

SKILL: Person-Centered Approach to Risk

Oscar

Oscar, a 27-year-old "man's man," lives in a group home with three other men he considers to be friends. He calls them his "brothers from other mothers." At home he often assumes the role of self-proclaimed "assistant" to staff, helping with daily tasks such as taking the trash out and grocery shopping for the house. He also likes advising his "brothers" how they too can become an "assistant." He's had a part time job at the local grocery store for the last two years, where many regulars know him by name. Oscar really loves his job there; he has been promoted from bagger to shelf stocker.

What Oscar enjoys the most is hanging out with "the guys" as often as possible, drinking and shooting pool at the bar around the corner from his house. He likes meeting new people there, especially women. Oscar has never had a girlfriend; he feels that drinking and showing off his pool shooting skills (he learned his skills from guys at the bar) helps the ladies notice him more. He hopes one day he'll be as lucky as some of men he knows—a lady will take him home after hanging out. Some of his co-workers from the grocery store have begun shooting pool there on the weekends. Oscar is embarrassed to bring friends over because he doesn't want them to know he lives in a group home. The house manager asks people to respect the midnight quiet hours in order to not disturb others. Oscar routinely makes it home by midnight. However, he often forgets to charge his cell phone before going out, and, on occasion, he has been too hungover to make it to work. On one of those occasions one of the support staff, a woman, encouraged Oscar to only have one drink at the bar from now on or "just hangout somewhere else." This infuriated Oscar, leading him to yell at her, "You are not the boss of me!" Unfortunately, he has spent time in jail for minor offenses such as bar fighting and public intoxication.

You provide support to Oscar. How would you evaluate various strategies to address risk and provide services in a safe and person-centered manner?

Additional Considerations for Providers

SKILL: Person-Centered Approach to Risk

Describe the activity / circumstance associated with risk

Oscar likes to drink and hang out in bars almost every night.

How is the activity / circumstance associated with what is important to / for the person?

It's important to Oscar to make and maintain relationships, be as independent and typical as possible. At the bar, he has access to many different potential new male and female friends. Being one of "the guys" here makes him feel independent. He also loves to shoot pool and gets to do it here. Also having his co-workers to mingle with makes him feel included both there and at work. It's important for Oscar to remain out of jail, be addiction free, be safe from unprotected sex, and maintain attendance at work in order to keep his job. This activity is important for Oscar to maintain an emotional sense of acceptance and confidence.

In supporting this person around this

What have we tried?	What have we learned?	What are we pleased about?	What are we concerned about?
Encouraging him to drink only one drink at the bar.	Limiting the drinking makes Oscar angry and feel like he is being controlled.	Oscar respects the curfew and doesn't wake others when he arrives home drunk.	Oscar could become addicted to alcohol, end up in jail for public intoxication while walking home, overindulge and get into a bar fight, have unprotected sex contact.

Based on above what solutions might we will we try next? Where do these solutions place us on the table below?

	Happy (important to)	Unsafe (conflicts with important for)
Safe (important for)	Ask Oscar if he's considered other activities he'd enjoy, where he can hang out with the guys and co-workers, that may not have as many safety concerns. Ask if he'd like any tips on ways to meet woman. Remind him to charge his phone in the afternoons. Ask if he feels having a friend to walk home with may help in avoiding police attention. Ask if he'd like tips to avoid a bar fight (to avoid possible jail resulting from the fight.) Remind Oscar to charge his phone more often so that when he goes out, if he needs a ride home or other help while walking home, he can call someone.	Don't address the risks at all. Tell Oscar he can do whatever he chooses to do.
Unhappy (conflicts with important to)	Tell Oscar he can have no more than two drinks. Ask the bartenders not to overserve Oscar. Encouraging other places to socialize, ask if he'd be interested in having his own pool table and inviting friends over to play. Talk about signs of alcohol poisoning and what to do if you experience them.	Don't even think of these strategies!

Additional Considerations for Providers

SKILL: Person-Centered Approach to Risk

Describe the activity / circumstance associated with risk			
How is the activity / circumstance associated with what is important to / for the person?			
In supporting this person around this			
What have we tried?	What have we learned?	What are we pleased about?	What are we concerned about?
Based on above what solutions might we will we try next? Where do these solutions place us on the table below?			

Things I want to remember

Things I want to remember

Things I want to remember

HCBS Peer Partners Project Grant

The workbook is funded by a grant from the California Department of Developmental Services. UCP WORK, Inc. is the lead agency, representing a regional project reflecting efforts of multiple providers that support individuals and families in the Tri-Counties Regional Center catchment area. This includes UCP-LA and Villa

Esperanza in Ventura County, UCP WORK, Inc., CPES/ Novelles, and Devereux in Santa Barbara and San Luis Obispo Counties. An ad hoc subcommittee of the TCRC Vendor Advisory Committee, comprised of service providers, regional center staff, and representation from the State Council on Developmental Disabilities (SCDD), implemented a survey of regional service providers. Upon reviewing results, the survey revealed a gap in getting HCBS information as well as Person-Centered Thinking resources to providers in outlying areas operating a small business which serve individuals and families.

The impetus for the efforts of the grant project is in aiding providers to understand how to meet the new HCBS Waiver Community Standards. The greater goal of the standards and this grant project is to support persons with developmental disabilities to have better lives, not just better paper. We endeavor to give the people we support more control over their services, receiving what is important to them: services supporting their own vision for the future and what is important for to be healthy, safe valued, members of their community.

Living Well In My Community

Part 4:
Planning My Good Life

How to use Living Well In My Community

Feel free to download this guide to use and share with others. Living Well In My Community was created to help people with disabilities and service providers better understand the rights and roles for living well in the community. Part 1 explains what the Home and Community-Based Services Rule is and how it can help people with disabilities to live in the community like other people without disabilities.

In Part 2, resources from Charting the Life Course can be used to create a vision of a good life in the community. Part 3 describes each characteristic of quality home and community-based services with some reflective questions to assess progress and areas for continued development. Examples of some person-centered approaches are introduced to help individuals with disabilities and providers move in the direction of a person's vision of a good life. The person-centered approaches described in Living Well In My Community will also be helpful to providers in meeting the home and community-based settings requirements. Part 4 has useful tips for working with a planning team to support a vision of a good life through person-centered planning, as well as an array of resources for more information.

HCBS Peer Partners Project Grant

The workbook is funded by a grant from the California Department of Developmental Services. UCP WORK, Inc. is the lead agency, representing a regional project reflecting efforts of multiple providers that support individuals and families in the Tri-Counties Regional Center catchment area. This includes UCP-LA and Villa

Esperanza in Ventura County, UCP WORK, Inc., CPES/ Novelles, and Devereux in Santa Barbara and San Luis Obispo Counties. An ad hoc subcommittee of the TCRC Vendor Advisory Committee, comprised of service providers, regional center staff, and representation from the State Council on Developmental Disabilities (SCDD), implemented a survey of regional service providers. Upon reviewing results, the survey revealed a gap in getting HCBS information as well as Person-Centered Thinking resources to providers in outlying areas operating a small business which serve individuals and families.

The impetus for the efforts of the grant project is in aiding providers to understand how to meet the new HCBS Waiver Community Standards. The greater goal of the standards and this grant project is to support persons with developmental disabilities to have better lives, not just better paper. We endeavor to give the people we support more control over their services, receiving what is important to them: services supporting their own vision for the future and what is important for to be healthy, safe valued, members of their community.

Acknowledgments

Thank you to the many contributors who helped in creating this guide

HCBS Peer Partner Advisory Committee
Dave Mulvey, HCBS Peer Partners Project Coordinator
Diva Johnson, Tri-Counties Regional Center
Harry Bruell, PathPoint
Judy Linares and Kathy Webb, UCP Work Inc.
Mark O'Keefe, Tri-Counties Regional Center
Mary Beth Lepkowsky, HSAUSA
Michele Ferrall, CPES/Novelles
Nikisa Simmons UCP-LA
Tina Calderaro-Mendoza, Tri-Counties Regional Center

Living Well In My Community was funded by a grant from the California Department of Developmental Services and includes principles and concepts developed by and used here with permission from The Learning Community for Person-Centered Practices. http://tlcpcp.com/

Stories and examples were contributed by Sue Goss, Diva Johnson, Rebecca Martinez, David Mulvey, Valerie Nix, Michael Kaszycki, Derek Smith and Mary Beth Lepkowsky. Others were generous in giving permission to share a variety of person-centered resources.

Helen Sanderson Associates USA
https://helensandersonassociates.com
John O'Brien and Beth Mount
http://www.inclusion.com/product/make-a-difference/
Line Plourde-Kelly Kapuskasing & District Association for Community Living (KDACL)
http://www.kdacl.com
Charting the Lifecourse
https://www.lifecoursetools.com

Editors: Mary Beth Lepkowsky, Dave Mulvey, Eugene Baldwin
Translations: Inline Translation Services.
Design: Julie Barclay

May 2020

Contents

Part 4: Planning My Good Life

Person-Centered Planning

"Person-centered planning grew out of a passionate concern to support people with developmental disabilities in discovering and contributing their gifts."

Connie Lyle O'Brien and John O'Brien

Home and community-based services requirements include each individual having a person-centered service plan that describes their long-term services and support needs for living well in the community.

Medicaid will cover home and community-based services only when a person-centered service plan (service plan) is created that addresses the person's long-term care needs as an alternative to institutionalization. Person-centered thinking skills introduced throughout Living Well In My Community, illustrate examples of people with disabilities having more positive choice and control in their lives. The skills offer multiple ways to have conversations to learn what is important to the person to be happy, content and fulfilled, and what is important for the person to remain healthy, safe and valued by others. The information gathered from those conversations can inform the person-centered planning process.

Person-centered planning is a way of listening to choices people make about the way they want to live...and making it happen. This approach to planning grew out of a passionate concern to support people with developmental disabilities in discovering and contributing their gifts.

There are many different methods of person-centered planning including PATH, Maps, Circles of Support, Personal Futures Planning, Essential Lifestyle Planning, Person-Centered Reviews, Liberty Plans, to name a few. A common element to all forms of person-centered planning is getting to know the person being supported by listening to their words and actions and listening to those who know and love the individual. The person-centered thinking and planning skills introduced throughout Living Well In My Community help to answer the questions:

- Who is this person?
- What gifts and capacities do they bring?
- What community opportunities will enable this person to pursue his or her hopes and dreams in a positive and successful way?

Through the person-centered planning process, the person receiving supports will:

- Identify their hopes and dreams (the Vision Tool in Part 2 can help with this).
- Identify what they like and are good at.
- Identify and set meaningful goals for living well in their community.
- Choose who will provide services and supports to help them meet their goals.

Planning will help the person think about things like:

- Where to live
- Who to live with
- Where to work or go to school
- Who to have for friends
- What to do for fun
- What to do in the future
- What services and supports the person wants and needs

Planning My Good Life

Person-centered planning is an ongoing process.

- It does not happen just once.
- The person can share their ideas in whatever way they communicate.
- The person with a disability may choose other people they want to have present.
- Person-centered planning can look different for each person, and that's okay.

The Planning Team

A person receiving home and community-based services might bring together a team of supporters who know and care about them to help with the planning process and participate as members of the "Planning Team." The purpose of the Planning Team is to identify opportunities for the person with a disability to develop personal relationships, participate in the community, increase control over their own lives, and develop the skills and abilities needed to achieve their goals. Successful person-centered planning depends on the commitment of a team of supporters who care about the person. These helpers take action to make sure that the actions discussed in planning meetings are implemented.

Who might be invited to be part of the Planning Team?

- The person receiving home and community-based services is the most important member.
- Parents and Legal Guardians.
- Direct support staff and other people who know and care about the person receiving home and community-based services.
- A service coordinator from the Regional Center who can arrange the services that are wanted and needed.
- Anyone else the person wants to include.

The Planning Team is especially helpful when:

- The person wants to check on progress and explore what is working and what is not working.
- The person wants to make a change to their person-centered plan or IPP (Individual Program Plan).
- The person would like help in thinking about some new possibilities.
- The person feels they are not being understood or listened to by current providers or other supporters.

Getting Started with Person-Centered Planning

The first step in the person-centered planning process is to think about who are the important people in a person's life. Who are the friends and supporters who can help? Some people will choose to have a lot of people in their circle of support. Others will choose very few, or perhaps no one else to help them plan. That's okay. The Relationship Map is a helpful skill to think this through.

HOW TO DO IT

SKILL: Relationship map

What it does

It captures who a person knows, how they know them, and how these networks and relationships can help a person to live the life they choose.

How it helps

It is a way of identifying who is important to a person, and to explore any important issues around those relationships. It feeds into person-centered support planning because it highlights those people who should be involved in planning, and helps to discover which relationships can be strengthened or supported.

How to use it

1. Map out the important people in the person's life.

Emotional closeness determines where names go in the relationship map, as opposed to how close a "blood" relationship is. The people who know the person well and care about them will be added to the circles that are closer to the center. This is based on connectedness and strength of feelings toward a person, and not necessarily how much time they spend with the person.

2. Find out who to listen to.

A Relationship Map gives us ideas about who we should talk with in order to develop a good picture of what is important to the person. It doesn't tell us whom to listen to. Asking a few questions will help us figure out who has a genuine relationship with the individual and who has nothing more than a working relationship. A staff member wanting to know whom to listen to should ask:

- What do you like about the person?
- What do you admire about the person?
- When's the last time you had fun together and what did you do?

People who have a working relationship will have difficulty answering those questions or may only answer from a "human service perspective." For example: What do you like about the person? "He has good hygiene."

3. Ask for permission to talk with people listed in the relationship map. People who have a genuine relationship will be more likely to talk about the person's positive gifts and qualities.

There may be times when you shouldn't do a Relationship Map. For example, if someone just experienced a significant loss of a family member or friend, they may be struggling with profound feelings of loneliness. On the other hand, it can help people to see who is there, whom they can count on, and whom they can trust.

Working With a Planning Team

SKILL: Relationship map

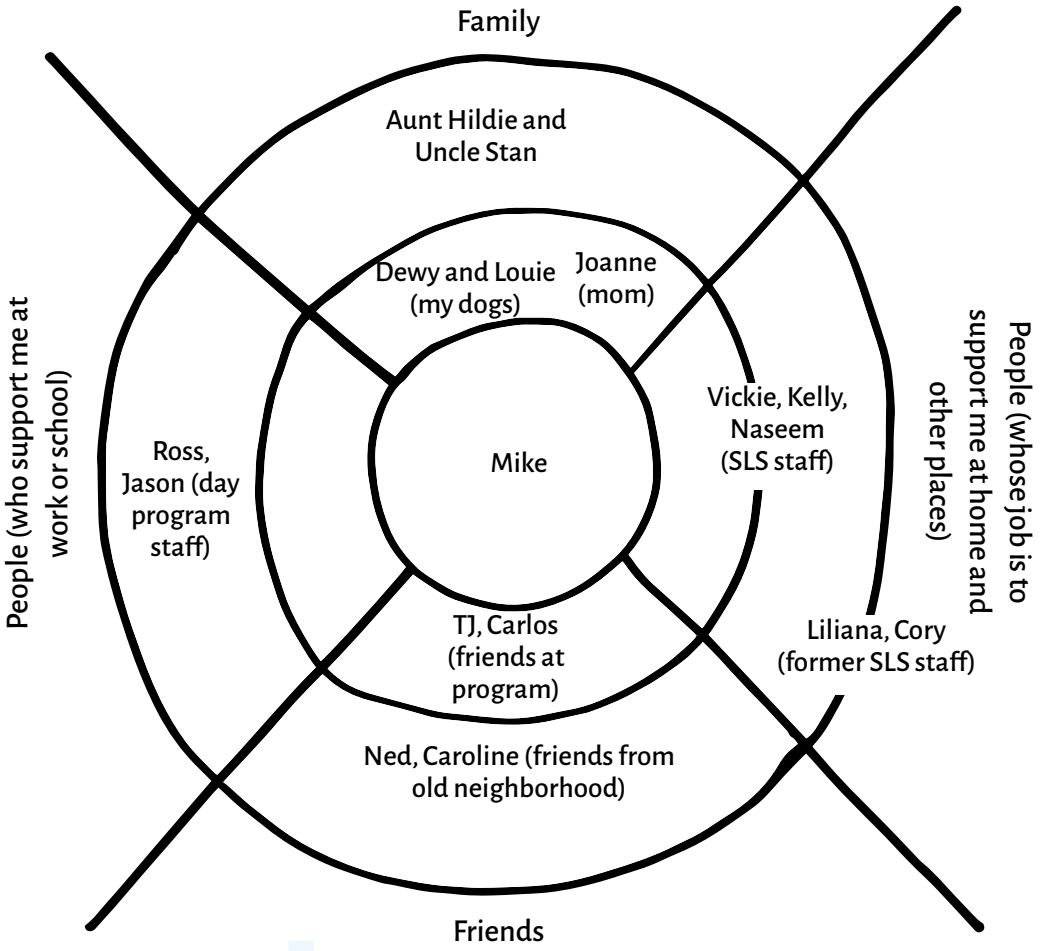
SHARING STORIES

Mike

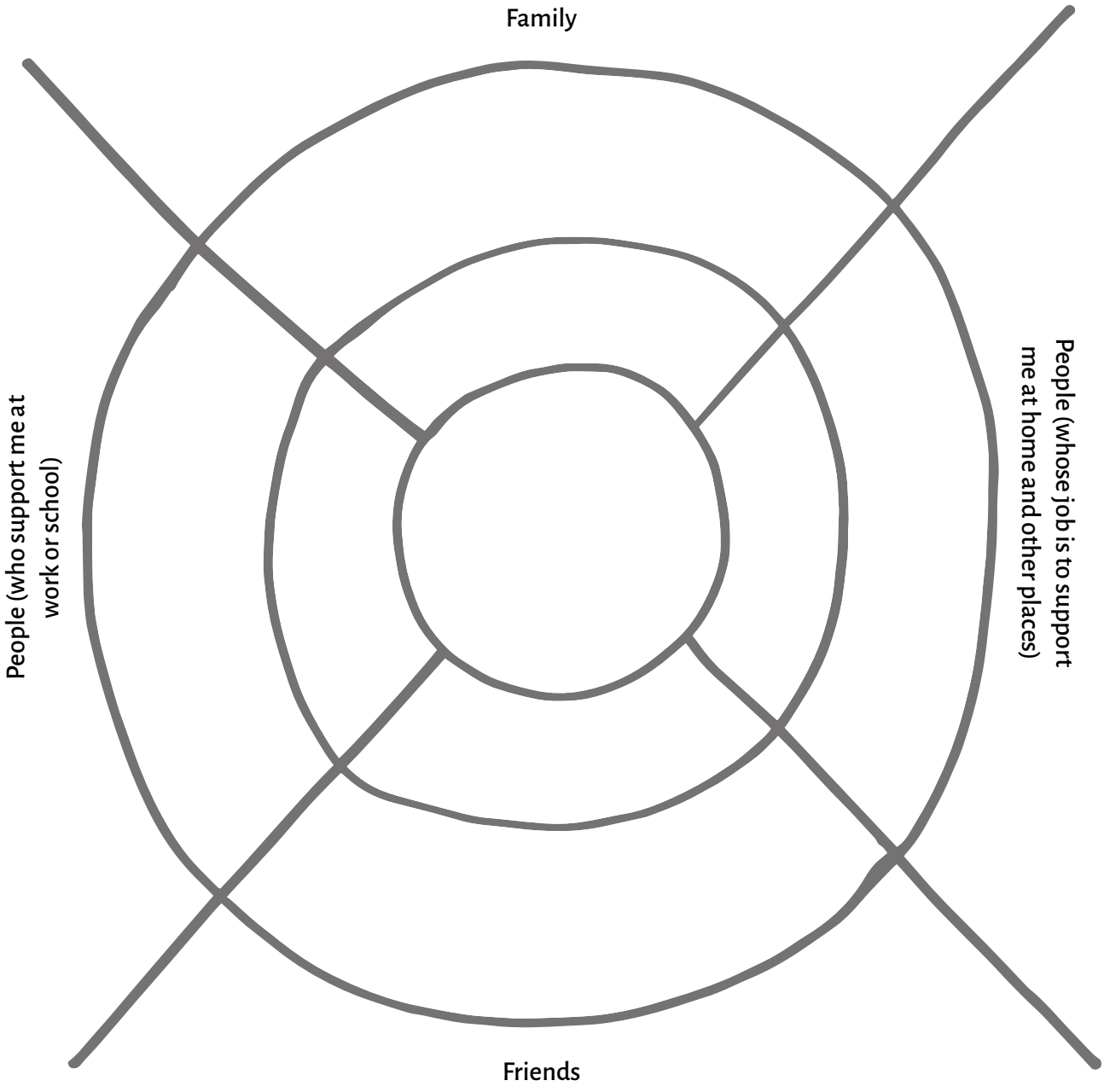
Mike had recently moved into his own residence with supported living services that he shared with friends in a city that was new to him. As a part of his Person- Centered Planning meeting he, his mother and his support team completed a Relationship Map. His current day program and supported living staff learned who their counterparts were in the city where he had previously lived.

Making those connections allowed his current support staff to share the learning of previous staff on what was important to and important for Mike, and how to best support him.

The current staff learned of relatives living near Mike's new home that staff could support Mike to visit. They also learned about Dewy and Louie, his mother's two dogs, who were very important to Mike and that Mike missed very much. Staff arranged for Mike to have regular visits to a local pet shelter where he could enjoy interacting with the dogs there.



SKILL: Relationship map



Working With a Planning Team

Working with a Planning Team

After completing a Relationship Map, and with a better understanding of who a person wants to include on their planning team, involve those people to:

- Gather information to create the person's life story.
- Explore with the person their opportunities for community participation, community presence, choices and expression of rights, respect and competence.
- Prepare a person-centered description that includes things the person enjoys doing and the things that the person prefers not to do.
- Create a One-Page Profile/ Description to include top tips about "What others appreciate about me." , "What's important to me" and "How to best support me." The One-Page Profile can be a wonderful introduction of a person and a great starting place for a Planning Team.

Planning Team meetings

A Planning Team meeting can be requested whenever the person wants to create or update their person-centered plan or work through issues or obstacles. Here is a summary of what might happen during a person-centered planning team meeting.

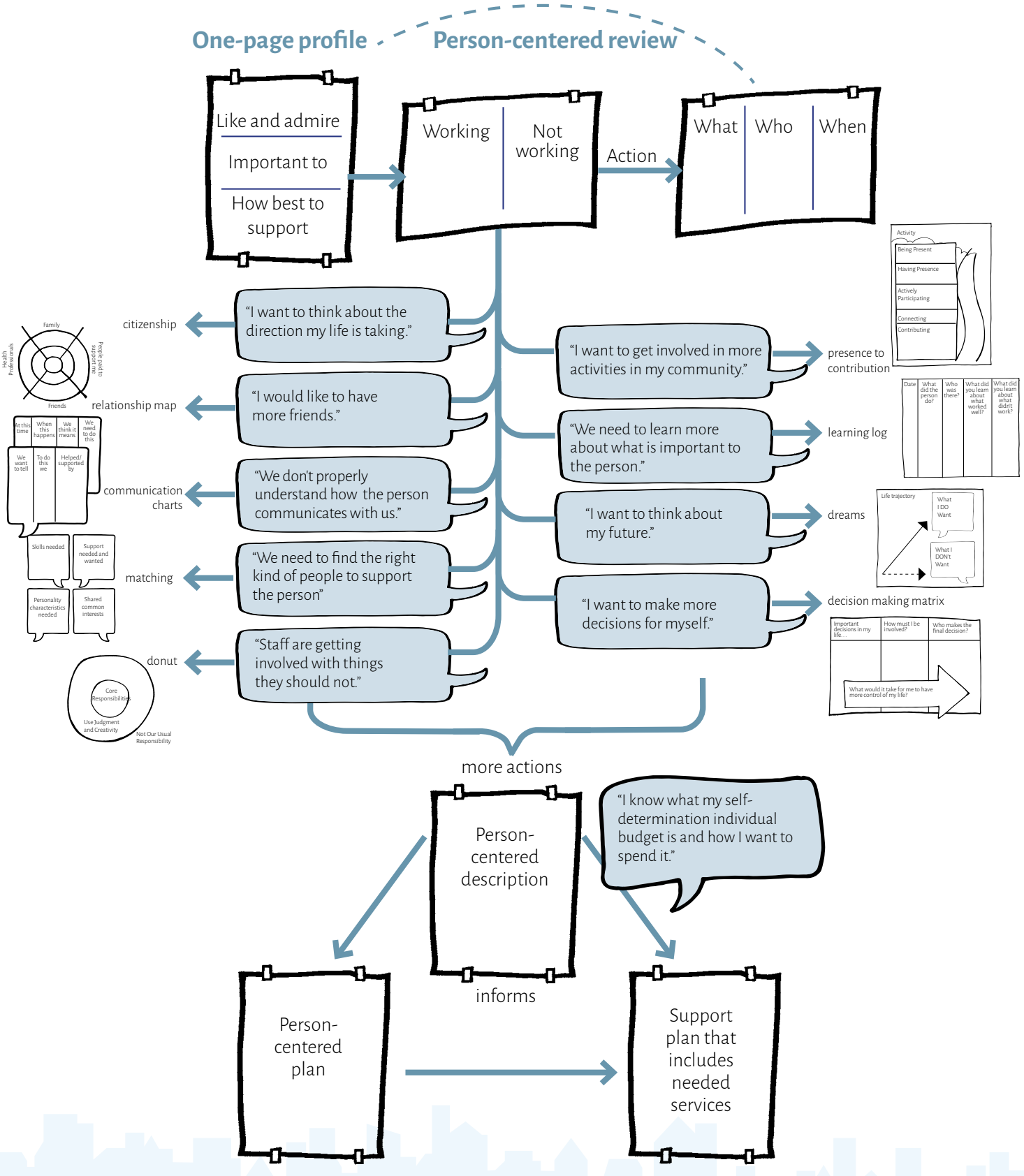
1. The person receiving support will decide on a purpose, agenda, time and place for meeting. Sometimes, the person may invite others to help with these logistics.
2. Create a welcoming environment. If meeting in person, consider light hospitality and arranging a room that is comfortable and not too formal. If meeting remotely through videoconferencing, allow time to make sure people can see and hear each other well and provide materials in advance. There are a number of virtual tools that can engage people well and support meaningful interaction.
3. When opening the meeting ask participants to introduce themselves and share something they like, admire or appreciate about the person with whom the team is developing a plan.
4. Review the person's one-page profile to find out what people like and admire about the person, what is important to them and how to best support them. (Learn about creating a one-page profile in Part 2)
5. Clarify the person's ideas about the future as they relate to the focus topic for the meeting (i.e., finding a new place to live, getting a job, meeting more people, learning to prepare meals and shop for groceries, etc.) (use the LifeCourse Trajectory in Part 2)

6. Next, the Planning team will review what's happening now in the person's life. This might include learning about the person's routines and rituals or what makes the difference between having a good day or a bad day. (see Part 3)
7. Consider what's working in the person's life that needs support to continue. Look also at what's not working in the person's life that may need to change. Record those opportunities and obstacles as they arise. The skills Important to / Important for and Working / Not Working are great for identifying what needs to stay the same and what needs to change or be added in the future. The image on the next page shows how different person-centered thinking skills can help the planning team explore different obstacles and opportunities. (Part 4)
8. Brainstorm possible next steps, make commitments for action, and identify the services and supports that are necessary to be more responsive to the individual's needs.
9. Set the time and place for the next meeting to check on progress and adjust the plan if needed.
10. Close the meeting by inviting each person to share one thing they appreciated about having time together.

It's important to remember that every person is different and every Planning Team will be different. The person receiving home and community-based services will drive the planning process and may use the steps listed above, or use a different approach that better suits their needs. The planning process continues with periodic check-ins to continue learning and update the person's vision, goals, needed services and supports, and actions. Ongoing use of different person centered thinking skills will make it easier to gather new insights that help the person move toward their vision of a good life in their community.

Working With a Planning Team

From one-page profile to person-centered plan



HOW TO DO IT

SKILL: Working / Not Working

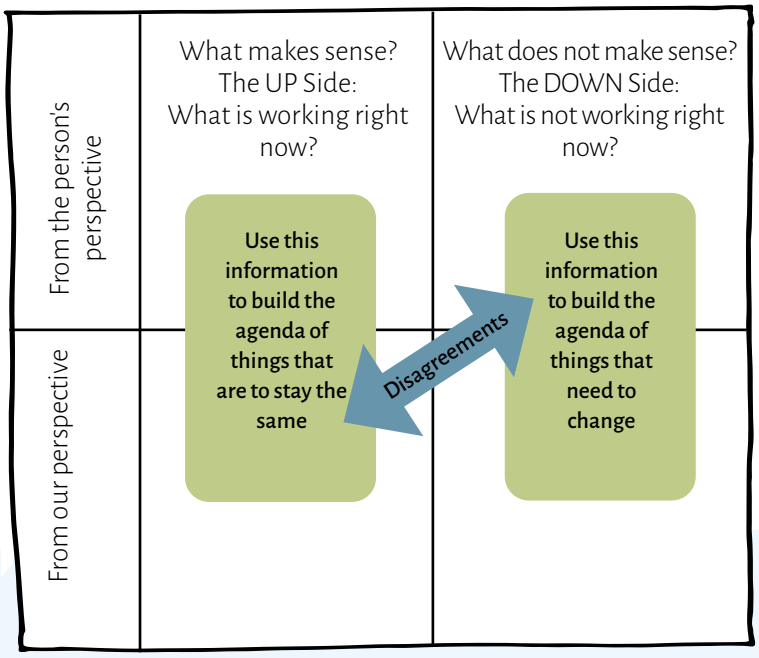
The Working / Not Working skill is a helpful way to start a person-centered planning conversation, or sort through issues with a planning team. It can help in recognizing those things that are working and need to remain the same, and those things that are not working and need to change.

What it does

This is an analytical tool that supports you in looking at a snapshot in time from multiple perspectives. It is a way to analyze a situation so that you capture what is working or making sense within that situation, as well as what is not working. In appearance, it is quite simple. Completed, it may be just four quadrants on a page.

How it helps

- It helps people gain perspective, to pause, step back and see the forest as well as the trees.
- It serves as a bridge between what was learned about important to/for and action planning.
- It helps get people unstuck, as it contains two of the core principles of negotiation. When you get each person's perspective on paper, they feel listened to. Teasing situations apart in enough detail can help you find areas of agreement; you start with "common ground."



How to use it

Facilitation of this skill involves several steps:

1. Create an environment where participants feel free to share honestly.
2. Invite participants to share their ideas about what's working and not working from their perspective. People can use words, drawings, or pictures to communicate their ideas.
3. Encourage participants to review what others have written. It may help them focus their thinking.
4. When people are done writing, ask for clarification as needed.
5. Look for areas where there is agreement on what is or is not working.
6. Where disagreement is present examine what it says about what is important to each of the participants.

SKILL: Working / Not Working

SHARING STORIES

Katarina

As a service coordinator, I made use of the Working / Not Working skill in developing a plan of action to address a problem brought to my attention by Juana, an administrator of a six-person community care home. Juana shared that Katarina, who lived in the home, was frequently arriving home from her day program in tears, stating she did not want to go back to the program. Katarina has a lot of spunk and loves being with her friends at the day program, so it was unusual for her not to want to go back. Katerina told Juana that staff had insisted on examining the contents of her backpack in front of all the other participants in the day program. Sometimes, they accused her of trying to steal items that were not hers. Katarina was embarrassed and angry. When I asked day program staff, they explained: In spite of being encouraged not to do so, Katarina was in the habit of leaving day program with her backpack stuffed with favorite belongings. They were also concerned that Katarina was frequently distracted, playing with things she had brought. Also, items belonging to the program, other program participants and staff would disappear, to be found days later in Katarina's backpack.

Staff had started to inspect Katarina's backpack each day before her departure, to check for missing items. The inspection took place in the main room of the program while Katarina and the other participants were awaiting transportation.

I invited Katarina, Juana and day program staff to meet with me to discuss the situation and try using the Working/ Not Working analysis. Staff informed me that they had learned of Working/ Not Working from someone who had attended training. They had already used the analysis, deciding that Katarina's theft of items was the primary thing that was not working and needed to be addressed. I pointed out that they had not sought out information from Katarina or Juana on their perspectives. In our meeting, we learned a lot more through using the Working/ Not Working analysis.

SHARING STORIES

SKILL: Working / Not Working

Based on what we learned, all parties agreed on several strategies to try to address the issues.

Katarina returned and was once again happy to be at her day program. While the solution was not perfect (Katarina would still on occasion forget to ask to borrow something), meeting privately with staff allowed Katarina to avoid embarrassment in front of friends and to be more receptive to feedback from staff.

	What is working?	What is not working?
Katarina	Bringing my favorite things to program in case I don't like the activity being offered. Being with my friends.	Being accused of stealing something I am only "borrowing."
Juana	Katarina attending day program every day.	Katarina coming home crying. Katarina upsets other people at home. Katarina refusing to go to program.
Day Program Staff	Katarina's unbridled enthusiasm and spunk. Working on arts and crafts projects.	Katarina being distracted from tasks. Katarina taking items that don't belong to her.

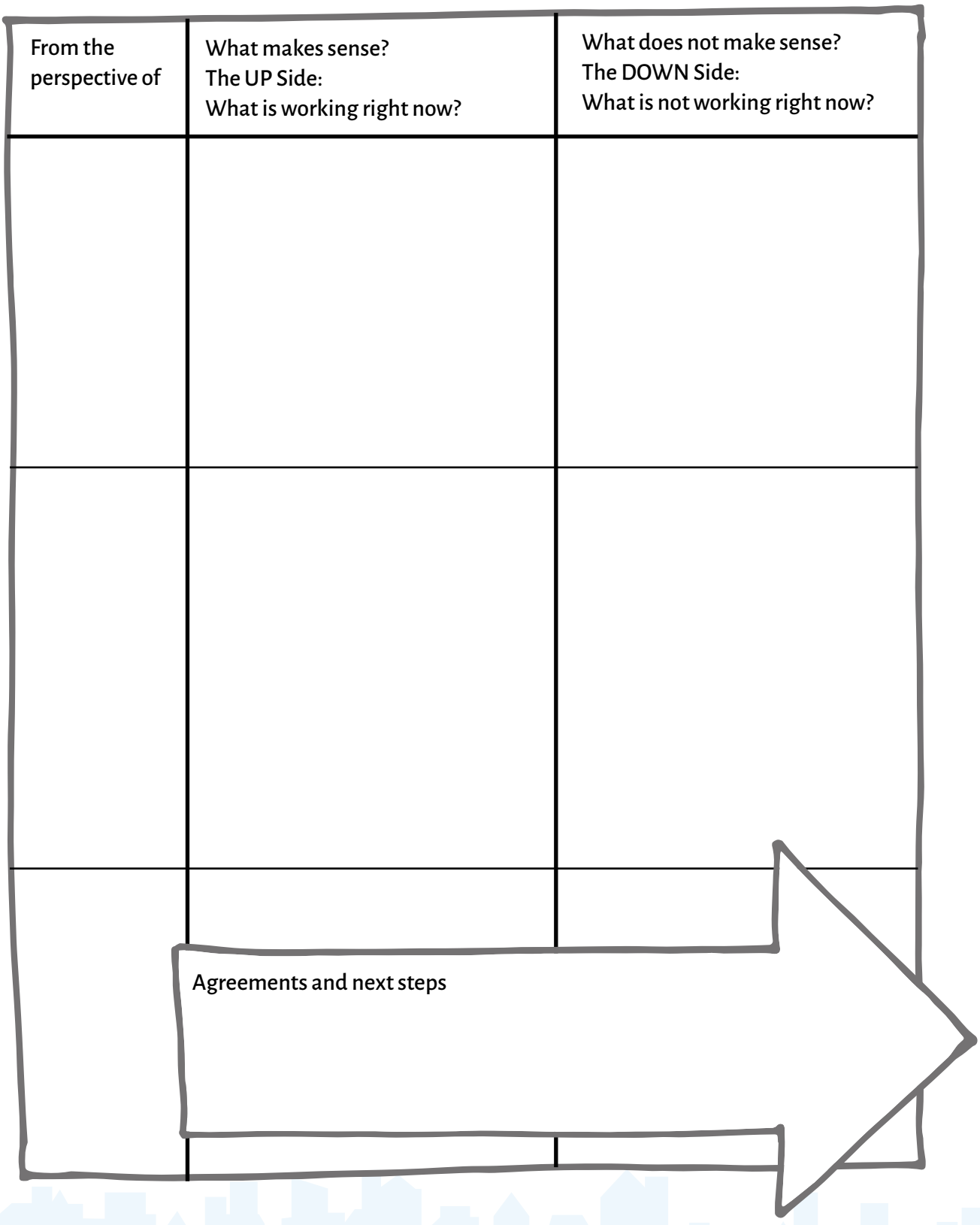
Agreements and next steps

- Day program staff, if they felt the need to inspect Katarina's backpack, will only do so one-on-one with Katarina in a private office.
- Katarina and Juana will try to reach an agreement on a much smaller (possibly see-through) bag to carry her things to program, and will limit the quantity of items she was bringing from home.
- Katarina agreed she will ask if there is an item she wants to borrow to take home.

Person-Centered Planning

SKILL: Working / Not Working

With respect to



Community Building Checklists

Things to think about and try as you support people to live well in their community.

Rate the following statements as follows

1 I haven't done this **2** I need help in this area **3** I am doing this

Relationships with family, neighbors, community

1. Do I support spontaneous visits to neighbors?	
2. Do I encourage the neighbors to visit with the person?	
3. Do I have a list of local clubs for possible membership?	
4. Do I ensure that the person's file has their name, address, phone number, birth dates, anniversary dates of immediate family, extended family members, friend and acquaintances?	
5. Do I support the person to send cards, letters, and make phone calls?	
6. Do I support events that draw neighbors into the person's home?	
7. Do I support the person to do things for the neighbor and his/her family (rake leaves, take laundry upstairs from laundry room, look after little children while mom runs for milk)?	
8. Do I find places where opportunities for the person to do things for others can occur?	
9. Do I support the person to participate in bake sales and other fundraising events?	
10. Do I support activities that help the person to be invited into other people's homes?	
11. Do I support the person to have a broadened focus of conversation?	
12. Do I ensure that the person has a photo album of immediate family, extended family, friends and acquaintances and their names?	
13. Do I support the person to have successful, positive visits with his/her family?	
14. Do I support the person to take pictures of themselves?	
15. Do I ensure that the person is on mailing lists?	
16. Do I ensure that the person makes donations?	
17. Do I educate around types of relationships?	
18. Do I support the person to re-establish relationships?	

Community Building Checklists

Members of the community

1. Do I support the person to have a birth certificate, Social Security card, health card, library card, credit card?	
2. Do I make sure that the person is on a mailing list for stores, political parties, school calendars, magazines, newspapers?	
3. Do I explain what home maintenance means?	
4. Do I support the person to donate time/money to canvas door to door, pass out bulletins, help with Sunday school/brownies/cubs?	
5. Do I support the person to become a member of his choosing in service clubs, church, hospital auxiliaries, world wildlife fund, etc.?	
6. Do I support the person's capabilities?	
7. Do I encourage the person to work in the community, at a job or volunteer?	
8. Do I assist the person to make choices to go to school for upgrading or special interest?	
9. Do I support the person to take responsibilities like babysitting, garage sales, street dances and wash cars?	
10. Have I done an inventory of transportation methods including car pools?	
11. Do I support the person to get around in the community?	
12. Do I support the person to go shopping for him/herself, errands for others?	
13. Do I support the person to become a valued customer in restaurants, convenience stores?	
14. Do I provide opportunities for the person to gain control (paying bills, taxes, rent and other bills)?	
15. Do I support the person in recreational pursuits and getting connected, such being a team member?	
16. Do I give support in a way that does not draw attention to the person?	
17. Do I know how to fade or withdraw support?	
18. Do I use various devices to teach the person membership in a group (role modeling)?	
19. Do I ensure the person has a communication system and respect the way the person communicates?	

20. Do I use assistive devices to support the person?	
21. Do I have an inventory of the person's assets?	
22. Am I able to match his/her assets to membership in a group?	
23. Do I encourage the person to be informed of his surroundings - newspapers, radio/ TV ads?	
24. Do I realize that the person needs support in choosing services (doctor, dentist)?	
25. Have I advocated for the person to be part of the interviewing team to hire his/her support worker?	

Advocacy for, with, on behalf of

1. Do I have an inventory of Support Services such as diabetes, sexuality, weight?	
2. Have I supported the person to have a will, trust fund, home ownership?	
3. What actions do I take to give control back to the person?	
4. Do I provide various options when the person is in a devaluing situation?	
5. Do I ensure that the home the person lives in is not the staff's residence?	
6. Do I support the person to ask for assistance when needed?	
7. Is the person a part of planning his/her schedules/routines?	
8. Do I value the individual as part of the decision making team?	
9. Do I advocate to local representatives for such things as accessibility?	
10. Do I support the person to join People First, youth groups in churches, choirs, barber shop quartets, dance groups?	
11. Do I support the person to make informed choices of where to work, where to live and with whom?	
12. Do I respect the person's disability?	
13. Do I inform and ensure that the person knows and understands the risks involved?	
14. Do I trust the person in his/her decision-making?	
15. Do I respect his/her privacy?	

Community Building Checklists

Fulfilling Hopes, Dreams and Aspirations

1. Am I able to put myself in the person's shoes?	
2. Can I see/experience life through the person's eyes?	
3. Do I know how to increase opportunities to support the person to make choices?	
4. Do I value the person's opinion?	
5. Do I listen to the person?	
6. Do I save the person from embarrassment?	
7. Do I speak to the person as an adult?	
8. Do I use a different tone of voice when speaking with the person?	
9. Do I support the person to communicate with his/her family regarding likes, dislikes, hopes, wishes?	
10. Do I support communication by various adaptive means?	
11. Do I speak about the person in a positive manner?	
12. Do I know how to provide opportunities for learning to occur?	
13. Do I know how to use various learning aids?	
14. Do I know the difference between responsibility vs. control?	
15. Do I build trust with the person?	
16. Do I support the person to plan for trips, vacations, items to purchase?	
17. Do I know how to set up connections for the person in the community?	
18. Do I compliment the person and instill self-worth?	
19. Do I offer suggestions?	
20. Do I share my ideas?	
21. Do I assist in identifying barriers to the dreams?	
22. Do I support the individual to take risks and make some mistakes?	
23. Do I support the individual in functional activities?	

Now

- Choose one of the items you rated as a 1.
- Think of a specific person you work with whom you could apply this item to.
- Develop an action plan how you will change it.

Adapted from 2006 Line Plourde-Kelly Kapuskasing & District Association for Community Living (KDACL)

The HCBS Peer Partner Program hopes the information provided in Living Well In My Community will be helpful. Continue to use the information in part, or in its entirety, to think, plan and act in support of someone using long term services and supports. Living Well In My Community is meant to be enough to get started. There are many other resources to enhance your understanding of home and community-based services and person-centered practices.

Service providers who deliver long term services and supports are encouraged to participate in Person-Centered Thinking Training developed by the Learning Community for Person-Centered Practices.

Those who have already participated in the training are welcome to join the local communities of practice meetings. For information about both, go to the Tri-Counties Regional Center website: https://www.tri-counties.org/ person-centered-practices/person-centered-thinking-training/

Those outside the Tri-Counties area can find information on training from their local Regional Center and from the **Learning Community for Person-Centered Practices**: https://tlcpcp.com/

Helpful websites

Websites with information about Person-Centered Thinking, Planning and Practices, and resources for online and in-person training.

Learning Community for Person-Centered Practices
https://tlcpcp.com/

Helen Sanderson Associates
http://helensandersonassociates.co.uk/us/
https://helensandersonassociates.com

Support Development Associates
https://www.sdaus.com/

Inclusion Press
https://inclusion.com/

Life Works Liberty Plan
https://www.lifeworks-sls.com/liberty-plan

Open Future Learning
https://www.openfuturelearning.org/index.cfm?fuseaction=login.home

Charting the Life Course
https://www.lifecoursetools.com/

NCAPPS National Center on Advancing Person-Centered Practices and Systems
https://ncapps.acl.gov/

Pacer's National Parent Center on Transition and Employment
https://www.pacer.org/transition/learning-center/independent-community-living/person-centered.asp

Resources

HCBS Resources

Accessing Home and Community-Based Services: A Guide for Self-Advocates. Autistic Self-Advocacy Network
https://autisticadvocacy.org/wp-content/uploads/2014/11/Accessing-HCBS-Guide-v1.pdf

System-Centered vs. Person-Centered. A video with Dr. Beth Mount
https://www.youtube.com/watch?v=y77y7XW8GtE

Home and Community-Based Settings Requirements Compliance Toolkit
https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-settings-requirements

The Council on Quality and Leadership HCBS – ACT Project (Advocates Creating Transformation)
https://www.c-q-l.org/resources/projects/the-hcbs-act-project/

California Department of Developmental Services HCBS Resources
https://dds.ca.gov/initiatives/cms-hcbs-regulations/

Person-Centered Planning instructional video clips

Introduction to the history of and various styles of Person-Centered Planning

Interview with Michael Smull on the evolution of person-centered thinking. Produced by the Research & Training Center on Community Living, University of Minnesota. September 30, 2015
https://www.youtube.com/watch?v=pYtDrbkZCps

Michael Smull - Definitions. What is meant by person-centered approaches, thinking and planning including PATH, MAPS Essential Lifestyle Planning?
https://www.youtube.com/watch?v=tvANuym5VXY&t=70s

Michael Smull conducting a person-centered planning meeting
https://www.youtube.com/watch?v=OQbs5JhKNXM

Helen Sanderson describing the person-centered reviews process
http://helensandersonassociates.co.uk/person-centred-practice/person-centred-reviews/

Julie Malette facilitating a person-centered review
https://www.youtube.com/watch?v=wxe-tB6wOz8

Information on specific Person-Centered Thinking Skills

Learning Log - Michael Smull introduces the Learning Log, a person-centered thinking tool
https://www.youtube.com/watch?v=JGsiWprN9bE

One Page Profiles - Michael Smull - How to get started using One Page Profile/Description
https://www.youtube.com/watch?v=meLjQX2wuhM&t=54s

Important to / Important For - Michael Smull introduces the person-centered thinking tool
https://www.youtube.com/watch?v=VDqERIxM4HM&t=80s

Communication Charts – Person-centered thinking tools to enhance voice, choice and control
https://www.youtube.com/watch?v=Yy7TnOqSLSo

Routines & Rituals, Good Day/Bad Day, Two Minute Drill - Michael Smull introduces person-centered thinking tools for understanding important to/important for
https://www.youtube.com/watch?v=vDRRD3hYaSg

Matching - Michael Smull introduces person-centered thinking tools for clarifying roles and responsibilities
https://www.youtube.com/watch?v=QbTXpowKFMQ

The Donut - Michael Smull introduces a person-centered thinking tool for clarifying roles and responsibility
https://www.youtube.com/watch?v=gCtxICX9118

4 + 1 Questions - Michael Smull introduces a person-centered thinking tool for analysis and action
https://www.youtube.com/watch?v=KYzxYcMN7sE&t=70s

Working / Not Working - Michael Smull introduces a person-centered thinking tool for analysis and action
https://www.youtube.com/watch?v=M190htHcvok

Things I want to remember

Things I want to remember