NCAPPS

Promising Practices for Person-Centered Plans

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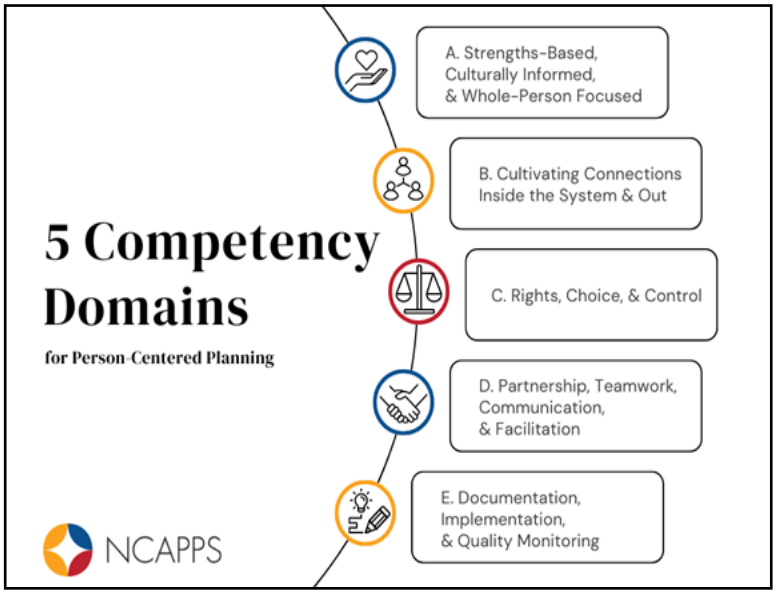
Introduction

As defined by the National Center on Advancing Person-Centered Practices and Systems (NCAPPS), person-centered planning is directed by the person with helpers they choose. It is a way to learn about the choices and interests that make up a good life and identify the supports (paid and unpaid) needed to achieve it. The person-centered plan is a written individualized plan based on the person's needs, goals, and preferences that helps them reach their vision of a good life. But what exactly does a "good" person-centered plan include or look like? What are some outcomes we might anticipate for the person? This resource outlines promising practices for person-centered plan documentation and describes indicators of truly person-centered plans for quality monitoring purposes.

Before you Begin

A plan can only be as good as the facilitator of the planning process. The NCAPPS Five Competency Domains for Person-Centered Planning describes five skill areas, or domains, that planning facilitators should have to support a fully person-centered planning process. One such skill area is focused on co-creating the plan with the person and reflecting their needs and wants in writing in a way that meets established expectations around person-centered plan documentation, such as the Home and Community-Based Services (HCBS) Final Rule Person-Centered Planning requirements. A person-centered plan is considered a "living document"; in other words, the plan should be revised as needed to align with the person's preferences and evolving needs. There should be responsible follow-up and monitoring of the plan's implementation. NCAPPS encourages the development of facilitator competencies and person-centered systems in tandem with any improvements to the plan itself. Additional resources to support this are available at the end of this document.



Person-Centered Language

Language is critical to showing respect for the person and humanizing them. The person's preferred name, language, and identities should be used throughout the written person-centered plan. Facilitators should write in a person-centered way by using either identity-first or person-first language depending

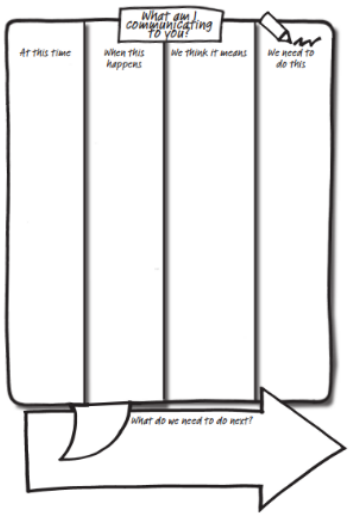
on the preferences of the person. The Employer Assistance and Resource Network on Disability Inclusion describes the differences between the two approaches:

> *Person-first language emphasizes the person before the disability, for example "person who is blind" or "people with spinal cord injuries." Identity-first language puts the disability first in the description, e.g., "disabled" or "autistic." Person first or identify first language is equally appropriate depending on personal preference. When in doubt, ask the person which they prefer. It is important to note that while person-first language is often used in more formal writing, many people with disabilities are choosing to use identity-first language. How a person chooses to self-identify is up to them.*

The chart below was adapted from the Resources for Integrated Care Tip Sheet on Using Person-Centered Language and provides examples of how simple changes in word choice can make language included in plans more person-centered while accounting for individual preference. Additional resources are included in the tip sheet.

Use…	Instead of…
Person/people without a disability	Abled-bodied, healthy, normal
Person or individual	Member, consumer, patient (outside of a health care encounter)
At risk for falls	A falls risk
Person with a substance use disorder, person in recovery	Addict
Person with an alcohol use disorder, person in recovery	Alcoholic
Person with, who has	Afflicted with, suffers from
Has barriers, experiences challenges, "often chooses not to do … because"	Non-adherent, non-compliant
Prefers not to, chooses not to	Resistant, refuses
Uses a wheelchair	Confined to a wheelchair
Accessible [entrance, restroom]	Handicapped [entrance, restroom]
Survivor	Victim, vulnerable

Plans should also be written in plain language and in a way that is understandable to the person. This could mean including pictures to represent ideas or action steps if the person can't read or finds visuals easier to understand than words. For people who are not fluent or proficient in English, facilitators should consult with the person to schedule interpreters for the planning process and/or translators to translate the plan into the person's chosen language if plain language or the use of pictures is not enough to help the person understand the plan.



If facilitators are not familiar with the person's communication style or preferences, they should spend some time learning how the person communicates by working with them and those who know the person best who make up their planning team (see the section on Roles for further detail). This can be especially crucial for people who communicate without speaking words such as through facial expressions, behaviors, and body language to ensure that they are still able to provide as much input into their plan as possible. The facilitator and person may find it beneficial to complete some version of a Communication Chart, which helps record how the person communicates and what others need to do to communicate back (e.g., signing, using images or objects). Completed communication charts, or brief descriptions of the person's communication style should be attached to or included in the plan. This can also include the person's communication triggers that may bring up trauma (e.g., topics of conversation, names, places).

Inclusion of Person-Centered Planning Tools

Facilitators may use person-centered tools as part of the planning process to generate discussion and organize information. Completion of specific tools should never be required to ensure that planning is flexible and adaptable. However, if tools are completed, facilitators should include them as part of the paper plan and electronic plans should have the capability for facilitators to upload completed tools and automatically attach them to the plan and/or the person's electronic record. Person-centered tools can contain rich information about the person, and it is important to find ways to ensure that this information is carried forward.

Person-Centered Tools and Templates

Please note that NCAPPS does not promote one tool or framework over the other.

National Models:

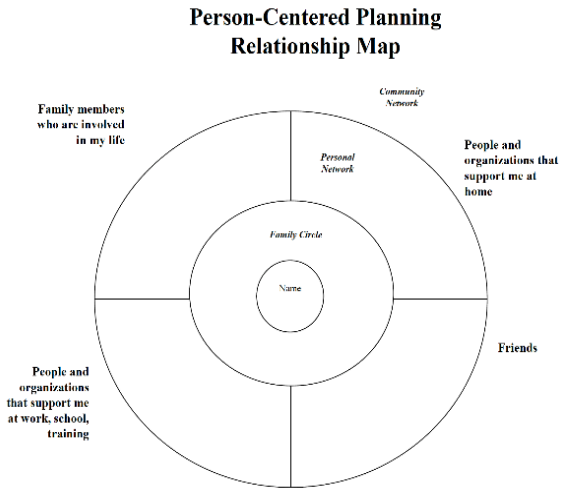
- Charting the LifeCourse: https://www.lifecoursetools.com/
- The Eden Alternative - Domains of Well-Being Framework for Self-Care Planning: https://www.edenalt.org/our-framework/
- Support Development Associates - Important To/Important For: https://sdaus.com/sda-resources/core-concepts-important-to-important-for/
- The PATH and MAPS Handbook: Person-Centered Ways to Build Community: https://inclusion.com/product/the-path-maps-handbook-person-centered-ways-to-build-community/
- Helen Sanderson Associates Person-Centred Thinking Tools: http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/

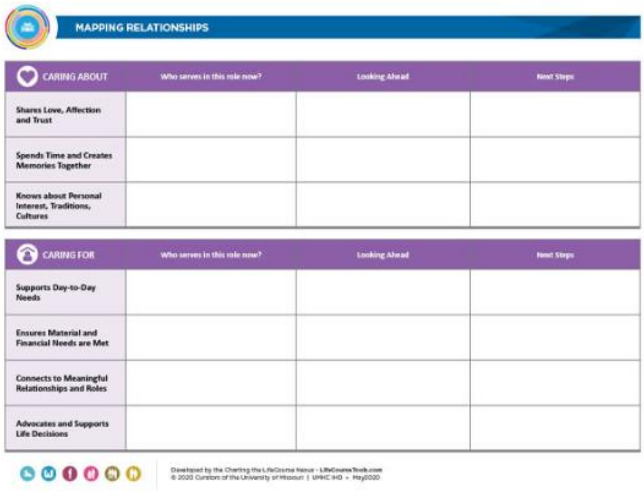
- Video playlist of Michael Smull, a pioneer in the field of person-centered thinking, introducing key person-centered thinking tools: https://www.youtube.com/watch?v=VDqERIxM4HM&list=PLB28A8993A3005CCD

Defining Roles within the Plan

The person-centered planning process must include people chosen by the person. Therefore, plans should document exactly who is part of the person's inner circle and the roles they play in the person's life.

Facilitators may find it helpful to use tools such as the Relationship Map or the Charting the LifeCourse Mapping Relationships to help the person identify who they would like to invite during the pre-planning process. Note: If used, the Relationship Map should identify the person's closest relationships and not a full list of all their known relationships. For example, a person may not be close to a specific family member, so despite being part of the person's family, that family member would be further out on the person's relationship map and the person would likely not want them to be part of their planning process.





While a person's planning "team" or "circle of support" will differ from person-to-person, some common participants may include the person's family members, significant others, friends, the person's service provider(s), Direct Support Professional(s) or DSW(s), medical professional(s), legal representative, etc. A "provider" in this context is defined as a funded person or organization supporting a person through services selected in the plan.

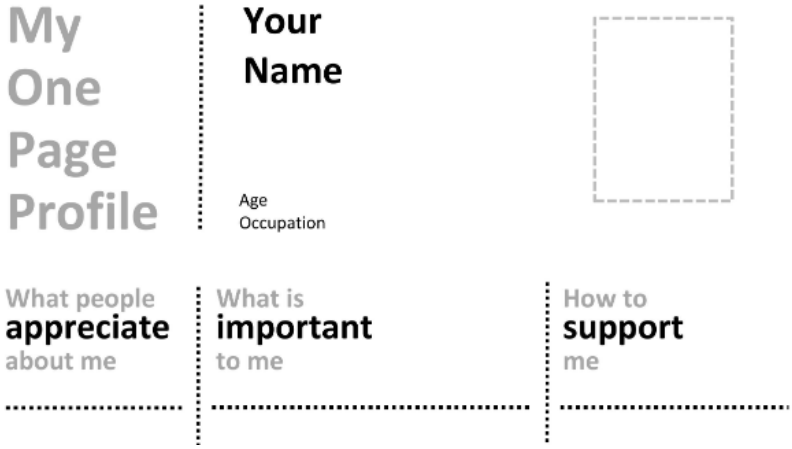
If referring to a member of the person's team within the person-centered plan, facilitators should include the team member's name and role in the person's life. For example, "Jane (mother) explained that …" or "John (husband) agreed that …" This could assist anyone in the future who may not be familiar with the person to fully understand the roles the person's team played in the planning process.

Formatting to Center the Person from the Beginning

Whether using an electronic or paper format, consider starting the written plan in a format similar to the One Page Profile, which provides a snapshot of the key points of the plan including the person's strengths and goals. This should be completed at the end of the planning process by the facilitator in coordination with the person but placed at the beginning of the plan itself to summarize and synthesize the critical information learned about the person.

This could include:

- A picture of the person to help provide them with a feeling of ownership and emphasize a focus on them. Pictures, however, should never be required and only included with permission from the person.
- Demographic information about the person that they feel is important for others to know such as their age, gender identity, occupation, faith, culture, etc. What identities does the person hold that they want to make sure are front and center?
- The person's strengths. Person-centered planning is strengths-based, not deficit-based, so center what skills the person has that can help them achieve their goals and what others appreciate about them.
- What is important *to* the person, i.e., what matters most to them by the person's own definition, such as their relationships, hobbies, interests, beliefs, routines, and more. This can be phrased as "what's important to me" or "what makes me happy" in the plan.
- What is important *for* the person, e.g., matters of physical and emotional health and safety by the person's own definition such as self-care, medication management, mental health, exercise, etc. This could be phrased as "how best to support me" in the plan.



Like with the rest of the plan, this beginning profile or summary should be reviewed and updated as circumstances change and on a yearly basis at minimum.

HCBS Final Rule Documentation Requirements for the Person-Centered Plan

According to Medicaid,[1] "home and community-based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses."

The HCBS Final Rule outlines the documentation requirements of person-centered plans for people receiving services under Medicaid HCBS programs.

The person-centered plan should:

Reflect …

- The setting where the individual lives or receives services was chosen by the person.
  - Facilitators should provide information so the person can make informed choices about the variety of service options and settings available to them (e.g., self-direction, day services, employment supports). Informed choice means that the person has the options, information, and knowledge about what each of the service options and settings would mean specifically for them and their lives. This should include opportunities to physically explore options in the community. Running down a list of service or setting types is not sufficient. Facilitators should take time to appropriately explain the person's options, encourage exploration, and answer questions.
  - When formatting the plan, this could include creating checkboxes for different service/setting types and offering plain language descriptions of each option in a popout window if using software or an appendix for paper plans so that facilitators have the information needed to accurately discuss the choices with the person.
  - There should be a description of what each provider will do to support the person in meeting their goals. Some goals (e.g., housing, education) may require services and supports not covered under the program funding the planning process. These providers and information related to their role in helping the person achieve their goals should be identified and included in the planning process. Descriptions could also include contact information for point people who could provide more detailed information if desired, e.g., the agency's self-direction coordinator or employment specialist.
  - The plan could also be formatted to include an open space or text box prompting the facilitator to describe their conversation with the person about the various settings offered to them and any feedback or comments that could inform the choice of future

[1] Home and Community Based Services | Medicaid

settings, e.g., "[person's name] said they aren't ready to move in with their partner just yet, but would like to do so in the future when they get enough money saved."

- Clinical and support needs as determined through a functional assessment. A functional assessment analyzes the child or adult's need or eligibility for HCBS by identifying the level of care needed. Each state has their own process and structure for how the assessment is done and who does it. It is important to note that the plan itself drives services and not the assessment. Additional information about functional assessments can be found in the National Health Law Program's Medicaid Assessments for Long-Term Supports and Services resource.
    - For electronic person-centered plans, assessment results could directly populate into the plan. For paper plans, facilitators might have a dedicated space to highlight key support needs.
    - Regardless of how assessment information is included in the person-centered plan, the person's current supports and services should tie directly to the needs determined through their assessment. This could include creating a way to link services and supports to assessment data in the electronic or paper plan.
    - Services and supports identified in the plan should tie to the person's plan goals.
    - All assessments that inform the plan should focus on the person's strengths and needs, so that services can work to boost existing strengths and fulfill needs.
    - Since the assessment will be used in some way to support the person's needs, it should allow the person and people important to them to answer questions or demonstrate what they need and can do. These findings should then be reflected in the plan in a strengths-based framework.
    - Keep in mind that person-centered plans informed by assessments done in languages other than the person's first language may have conflicting or confusing information. Therefore, the assessment should be available in the languages commonly spoken in the state and should be properly translated and tested with people who speak those languages.
    - In the context of the planning process, it may be necessary to share what formal processes are in place to support people who believe that the assessment has not captured their needs adequately so that people can assess needed changes to the assessment or a reassessment.

- The person's strengths and preferences.
    - Since a functional assessment will be conducted, be sure the resulting documentation in the plan centers people's strengths and preferences, including information not revealed by a formal process.
    - Preferences should include likes and dislikes across all life domains. This can be formatted to describe what a good day looks like for the person or their routines.

- Discovery tools such as Good Day/Bad Day, Perfect Week, Relationship Map, Communication Chart, etc., are all ways to learn about strengths and preferences.
    - Note: It is also not always feasible, necessary, or desirable to use all these person-centered tools at the beginning of a planning process or all at once. Discovery is an organic, ongoing process, and the tools should be used more than once over time to continuously learn about people's changing preferences.

Identify …

- Who will be responsible for monitoring the plan.
    - All plans should be living documents, able to be readily updated at the person's request and therefore, it is critical that the document itself reflects both how the plan can be revised and who is responsible for overseeing the implementation of the plan through regular monitoring. Facilitators should include direct contact information for who the person can reach out to if they want to make changes to their plan.
- Services and supports—both paid and unpaid—that will help the person achieve their goals.
    - Services and supports that are person-centered will ensure the alignment of services and systems so that the person has access to the full benefits of community living and will facilitate the achievement of the desired outcomes stated in the plan.
        - Consider the specific needed relationship between the roles of various providers to ensure a goal in the plan is reached. For example, an employment goal may require changes in personal assistance, meals, transportation, employment supports, social interests, financial supports, etc. This may require more than one provider to accomplish.
        - Coordination of services, a shared understand of the person's strengths and preferences, and the sharing of ongoing learning are necessary to achieve the best outcomes.
    - Service availability should not be a driving factor in plan development. Instead, the opposite should be true. The plan obligates the system to provide identified supports and services. Service gaps across plans should be aggregated and used to develop needed services.
- The provider of these supports and services must also be identified, along with any natural supports.
    - Natural supports are voluntary, unpaid supports that an individual receives from their everyday relationships.

- Provider services are paid supports provided by an entity selected by the person.
- All providers and natural supports should be selected by and reflected specifically in the plan including who will do what, how often, by when, and resulting in what.

Include …

❖ Goals and desired outcomes identified by the person.

- Goals are what the person wants the result to be and not their services or supports. Goals should be personal, written in plain language and in the person's own words so they are easily understood, and representative of what the person wants and will commit to.
- When writing goals, facilitators should use person-centered language including the person's name, or "I" statements. Avoid using "will" or "should"; and use "would like" or "wants" instead. For example, "John wants to…" instead of "He will…" or "I would like to" instead of "They should…"
- Avoid goals that the person has no interest in, just require attendance or participation, emphasize the absence of something, or focus on the "improvement" of deficits associated with the person's diagnosis.
- The facilitator should discuss with the person how they, and others supporting them, will know that they have reached their goals. What are the signs that a goal is "complete"? How will each specific service contribute to goal achievement? Person-centered plans should include a description of anticipated outcomes for the person so that progress can be tracked accurately.
- Goals should include a review date and a process for assessing progress based on the goal, how quickly it can be achieved, and any challenging factors. This review could include goal attainment scaling, or other approaches and should be as frequent as appropriate for the person and the specific goal. Goals should be assigned to particular quality of life domains such as the Charting the LifeCourse Life Domains, National Quality Forum HCBS Quality Domains or others.
- There is no universally agreed upon method for writing person-centered plan goals and states and individual facilitators may use approaches ranging from SMARTIE to Locke and Latham to micro-goals. Regardless of format, goals should be written in the person's own words where possible and operationalized to be measurable and achievable through discussion with the person.
    - If a state has mandated a specific approach to goal writing, they should consider formatting the goal section to align with the chosen method and offer question prompts for the facilitator. For example, if a state has selected to use the SMARTIE goal format, the goal section of the plan could include an outline of the acronym.

- Note: States should weigh the pros and cons of requiring goals to be written in a specific way. While mandating specific goal writing methodology can help provide structure for facilitators, it can also make goal setting inflexible.

❖ Risk factors and measures in place to reduce risk, including backup plans and strategies as needed.

- Risk is the potential for something bad to happen and is a part of our everyday lives. Risk factors are choices, actions, behaviors, situations, environments, or conditions that make an undesirable event or negative outcome more likely to occur.[2] Risk factors should be contextualized by the person as each person has their own perspective on what is or is not an acceptable level of risk for themselves.
- Plans should include an identification of the person's individual risks and describe why it is a current risk based on factual, objective information about the person, their history, environment, and prior actions.
- A brief assessment of each risk should also be included, e.g., how serious is the risk and what is the likelihood that it will occur based on the person's history?
- The person-centered plan may include another plan within it: the person's backup plan. Different from any type of risk remediation, a backup plan is a contingency plan to ensure the person's needs are met in case their services and supports are temporarily unavailable for any reason such as a natural disaster or direct support staff having an emergency.
    - Backup plans may include detailed contact information such as telephone numbers, email addresses, or physical addresses of a person's natural supports or informal caregivers who could be called upon to temporarily support the person if needed.
    - Backup plans should include information about what to do in case of natural disasters and should specify people's preferences for what happens if they need to evacuate their environment.
    - They could also include details about potential assistive technology that could support the person or where and how to locate backup services and supports.
    - Backup plans may also include details such as timing for when to further escalate a response. For example, if a person who tends to wander has been gone for an hour, the plan may be to have a loved one check-in with them by

[2] https://www.dhs.pa.gov/providers/Providers/Documents/LTC%20Providers/Risk%20Mitigation%20PowerPoint.pdf

calling them on their cell phone. However, if the person has been gone longer than five hours, that may be a sign that we need to get law enforcement involved to help locate the person.

- ❖ Any services that the person may choose to self-direct.
    - In self-direction, people control their HCBS including choosing what services, how much, and who provides them (sometimes even family or friends). As noted earlier in the section on informed choice, it can be helpful to include a brief description in the plan of self-direction and contact information for a representative who can help the person learn more.
    - Self-direction options should ideally be available broadly across all services to allow the person to select and direct supports outside of the context of traditional provider agencies and allow for greater flexibility in choice of service setting.
    - In the context of identifying who will provide services named in the plan, any services the person chooses to self-direct should be described as such in the plan.

Be ...

- ❖ Written in plain language or in a manner that is understandable to the person.
    - The plan should be written with the person in mind as a reader and user of the document. Additional information can be found earlier in this resource in the "Person-Centered Language" section.
    - Plain Language and Easy Read Resources:
        - https://www.plainlanguage.gov
        - https://www.sabeusa.org/wp-content/uploads/2014/02/GuideToCreatingAccessibleLanguage.pdf
        - https://autisticadvocacy.org/policy/toolkits/
        - https://autisticadvocacy.org/wp-content/uploads/2021/07/One-Idea-Per-Line.pdf
        - https://selfadvocacyinfo.org/wp-content/uploads/2019/08/Plain-Language-Resources.pdf
    - In recognition of the different languages people may use, consider this resource on Easy English versus Plain English: https://centreforinclusivedesign.org.au/wp-content/uploads/2020/04/Easy-English-vs-Plain-English_accessible.pdf

- ❖ Agreed to by the person. They must provide written, informed consent to the plan and sign off on it with their signature and date. The providers who are responsible for carrying the plan out must also agree, date, and sign the plan.
    - The person with and for whom the plan is written owns it. They must approve all content and indicate this agreement by signing off on the plan document itself. For electronic plans, this could include some type of dated electronic signature or approval.
    - As noted earlier, facilitators should document the various options the person was presented with throughout the planning process and indicate that they have expressed (in their own communication style) that they agree to what is outlined in the plan.
    - Providers of selected services identified in the plan should also be informed and agree to the plan by signing it either on paper or through an electronic method.
    - Distributed to the person, and others involved in the plan. The person's full plan should be distributed to all who play a role in providing services and helping the person meet and monitor their goals.
- ❖ Prevent any unnecessary or inappropriate services and supports …
    - In being person-centered, plans should identify needed supports and services and avoid imposing unnecessary and unwanted interventions or supports.

Document …

- ❖ All the home and community-based settings that were considered by the person.
    - Having presented choices and different options to the person, the plan should reflect what those options were and that they represent a variety of settings such as the person's own home or apartment, group settings, etc.
- ❖ Strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.
    - Before getting too far into the planning process, facilitators should support the person and their team to identify how decisions will be made when people involved in the process do not agree. Therefore, there should be a space early in the written plan to prompt facilitators to document agreed-upon strategies for addressing conflict. Strategies could include taking breaks, creating a comparison chart of people's perspectives to see where there is alignment or disagreement, or engaging in a formal or informal supported decision-making process.
    - The plan should also document that people involved in the process do not have obligations greater than those to the person so that there is no conflict of interest. If

there are conflicting interests, conflict of interest guidelines should specifically outline if certain team members should not provide input or influence aspects of a person's life if they could benefit from it either personally or professionally.

- Any modification or restriction of the person's rights as outlined by the HCBS Final Rule must be supported by a specific assessed need and justified in the person-centered plan. This requirement is meant to minimize the abuse of right restrictions and should therefore be applied to all settings, e.g., residential, employment, community. At times, a person's rights may need to be modified or restricted to ensure their safety or the safety of others. In these instances, the following requirements must be documented in the person-centered plan:
    - Identify a specific and individualized assessed need for the modification.
        - An "assessed" need means that there is data, history, or other evidence to support that the person needs the modification.
        - A "modification" functions to impose restrictions and as such must be carefully considered and documented as described below.
        - A person's diagnosis or disability is not a sufficient justification for a modification in and of itself.
        - A person's rights cannot be modified or restricted out of fear that something *could* happen. There must be documentation of why the person needs the modification, such as prior events or outcomes.
        - Modifications should incorporate knowledge gathered elsewhere in the plan around what is "important for" the person.
        - Modifications should be specific to the person and not imposed on a group of people. When necessary and when one person's modification affects a group of people, there must be a way for others without the modification to circumvent the modification.
    - Document what was previously tried to avoid putting the modification in place, including supports or positive behavior strategies.
    - Document less restrictive methods that have been tried but were unsuccessful or failed to meet the person's needs.
    - Include a clear description of the hazard to the person's health and safety.
        - Restrictions should be as minimal as possible. The assessed need rather than fear of future risk should determine the plan.

- Include a way to regularly gather and review data to determine whether the modification is helping the person over time.
    - Facilitators should define with the person and their team what outcomes would need to be observed to minimize or remove the modification. This could include quantitative or qualitative data.
    - This should also include information about what data or outcomes would need to be observed to minimize or lift the modification.
- Include information about how often the modification will be reviewed to determine if it is still necessary or can be removed.
    - Modifications are time-limited and must be regularly reviewed with the person and their team to identify whether it is still needed.
    - Facilitators should determine the frequency of the review of the modification with the person and their team. Plans can be formatted to require documentation of the next review date of the modification.
    - If the data shows that the modification is not helping the person, the facilitator must discuss and document other things to try with the person and their team.
- Include the person's informed agreement to the modification.
    - Like the rest of the person-centered plan, the modification must be written in a way that is understandable to the person. The person should understand what the modification is, why it is necessary, when the modification will be reviewed, and how it can be minimized or removed in the future.
    - Unless the person has a legal guardian or a person with similar decision-making authority for them, the person is the only one who can provide consent. Even if the person has someone serving in such a role, it is important to determine if the guardian has the authority to make such a decision for the person, especially if there is conflict between the person and the guardian over whether to consent to the modification.
    - If the person does not consent to the modification and their team is concerned that the lack of modification will lead to harm for the person or others, there should be a state policy or process related to emergency rights modifications or modification review processes that can help the person and the team determine next steps or come to a consensus. A copy of this policy should be linked in an electronic plan or attached to a paper plan.
- Include a guarantee that the modification will not harm the person.

- Modifications must never cause harm to the person in any way— physically, emotionally, mentally, etc.

Quality Monitoring

We hope you will consider the following questions when reviewing person-centered plans for quality purposes:

- Does the person report that they feel like the plan reflects who they are?
- Has there been an effective discovery process that reflects that the facilitator gained an understanding of what is important to/for the person?
  - Did the plan facilitator use the discovery information to develop goals in the person's own words?
- Are goals linked to services and supports that are not limited to what a particular program pays for?
- Does the plan reflect what the person may want to figure out in their life or to explore in the community and is there a place to capture what is learned?
- Does the plan show that there was explicit probing for the elements required in the HCBS Final Rule, including employment and community inclusion?
- Does the plan present the person in a positive light (picture, positive attributes, etc.)?
- Is there a summary page early in the plan that describes in plain language how to best support the person?
- Is there a method in place for person-reported progress on goals? Are results being assigned to domains of care, aggregated across service providers, and used in quality improvement projects?

In thinking about how your system approaches planning, consider asking these questions of the planning process:

- Is there a way to reflect what is learned about the person on a day-to-day basis and share with others?
- Are plans being updated in a flexible and responsive way? Is the process for updating the plan rooted in the person's preferences and needs?

Additionally, consider the following cautions when working to improve the quality of person-centered planning through structuring how the system does annual service planning:

- Avoid reducing the person-centered planning process to a checklist-driven written document. The plan is as much the process you engage with the person in prior to and following the written document as it is the document itself so ensure your process and capacity allow for robust engagement with the person for whom the plan and services exist.
  - The plan document itself is always reflective of a plan process that is the central contributor to person-centeredness. The person-centeredness of your process drives how person-centered your plan can be. Make space in the structure and process for person-centeredness.
- Any plan is only as valuable as the work done to implement it after it is written. Anything less is the creation of additional harm for the person.

    - Avoid emphasizing the plan document at the expense of system capacity to provide person-centered services in ways that produce the outcomes in people's lives stated in plans as goals. People with disabilities have experienced a myriad of letdowns from human service systems, so be sure the planning process doesn't set up yet another false promise.
- The degree and depth or extensiveness of planning should align with the needs of the person to avoid imposing more planning than is appropriate at the particular time in life.

NCAPPS Resources

Below are key resources from NCAPPS that anyone can use to build more person-centered systems and facilitate person-centered planning processes. A full list of resources can be found on the NCAPPS Resources webpage.

1. Webinar - *Using NCAPPS Resources to Support Compliance with the Home and Community-Based Services Final Rule Requirements for Person-Centered Planning*: Provides an overview of the NCAPPS Person-Centered Practices Self-Assessment, Five Competency Domains for Person-Centered Planning, and Asset Mapping Toolkit.
2. Person-Centered Practices Self-Assessment: Developed as part of NCAPPS technical assistance, this self-assessment is designed to help leadership at human service agencies in states, tribes, and territories to measure their progress in developing a more person-centered system. It contains questions about observable practices across eight system domains: Leadership; Person-Centered Culture; Eligibility and Service Access; Person-Centered Service Planning and Monitoring; Finance; Workforce Capacity and Capabilities; Collaboration and Partnership; and Quality and Innovation.
    - Plain Language Version
    - Español
    - Webinar: *What Does a Person-Centered System Look Like? Introducing the NCAPPS Person-Centered Practices Self-Assessment*
3. Five Competency Domains for Person-Centered Planning: This resource, which builds from foundational approaches to person-centered planning and the 2020 National Quality Forum Person-Centered Planning and Practice Final Report, describes five skill areas, or domains, that facilitators should possess to support a fully person-centered planning process: A. Strengths-Based, Culturally Informed, Whole Person-Focused; B. Cultivating Connections Inside the System and Out; C. Rights, Choice, and Control; D. Partnership, Teamwork, Communication, and Facilitation; and E. Documentation, Implementation, and Monitoring.
    - Plain Language Version
    - Webinar: *Doing With, Not Doing For: What it Takes to Facilitate Person-Centered Planning*
4. Asset Mapping: Asset mapping is the process of mapping out (e.g., with visuals or lists) how ways that an agency and/or its allies have engaged with community members. Developing an

asset map provides the opportunity to identify existing groups, communication practices, trusted relationships, and products to springboard from as opposed to starting the engagement process from scratch. This toolkit contains a variety of resources—frequently asked questions, a glossary of terms, step-by-step instructions, facilitator tools, and example asset maps and engagement plans—to support human service agencies in their stakeholder engagement efforts.
    - Toolkit for Asset Mapping
    - Workgroup Meeting Guidelines
    - Asset Mapping FAQ
    - Webinar: *The PAE Attention Framework: Understanding the Ingredients for Successful Stakeholder Engagement*
    - Webinar: *Meaningful Stakeholder Engagement: A Collaborative Approach to Programs for People with Intellectual and Development Disabilities and Their Families*
5. Engaging People Who Receive Services: A Best Practice Guide: This best practice guide is designed to assist human service systems to fully and effectively include people who receive services in system planning and improvement efforts.
6. Person-Centered Thinking, Planning, and Practice: A National Environmental Scan of Foundational Resources and Approaches: An annotated summary description of foundational resources and approaches for person-centered thinking, planning, and practice.
7. Person-Centered Thinking, Planning, and Practice: A National Environmental Scan of Indicators: A national review of indicators that may be used to assess person-centered principles in aging and disability systems, including mental health systems.
8. Person-Centered Thinking, Planning, and Practice: A National Environmental Scan of Definitions and Principles: A national overview of person-centered principles across aging and disability systems, including mental health systems.
9. Person-Centered Planning Facilitation: Summary of Research and Findings: This overview of person-centered plan facilitation services explores the experience of states that have specifically included plan facilitators in their HCBS waivers, the circumstance under which the states deploy plan facilitators, the rates paid, and training requirements.
10. Person-Centered Thinking, Planning, and Practice: Representative Examples of State Definitions: Although there are now a range of strong national definitions of person-centered thinking, planning, and practice, many state human service agencies find it important to develop their own local definitions for use in policy statements and implementation protocols. This environmental scan serves as a starting point for state, tribal, and territory human service agencies as they operationalize person-centered approaches in their local contexts.

About NCAPPS

The National Center on Advancing Person-Centered Practices and Systems (NCAPPS) is an initiative from the Administration for Community Living and the Centers for Medicare and Medicaid Services to help states, tribes, and territories to implement person-centered practices. It is administered by the Human Services Research Institute (HSRI) and overseen by a group of national experts with lived experience (people with personal, first-hand experience of using long-term services and supports).

NCAPPS partners with a host of national associations and subject matter experts to deliver knowledgeable and targeted technical assistance.

You can find us at https://ncapps.acl.gov

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