



# Office for People With Developmental Disabilities

## Workforce and Talent Management Training Curriculum Series



# SUPPORTING PERSON CENTERED OUTCOMES

An Introduction to Person Centered Planning

Instructor's Manual



## **Agency Requirements for MSC Course Delivery**

The MSC curricula found on OPWDD's website [www.opwdd.ny.gov](http://www.opwdd.ny.gov) may be delivered by provider agencies that meet certain specified conditions.

For information, please go to:

[http://www.opwdd.ny.gov/opwdd\\_careers\\_training/training\\_opportunities/documents/msc\\_agency\\_requirements\\_train](http://www.opwdd.ny.gov/opwdd_careers_training/training_opportunities/documents/msc_agency_requirements_train)

**If you have any questions, please contact OPWDD Talent Development and Training at (518) 473- 1190.**

February 27, 2014





## Instructor Requirements for MSC Delivery

Instructors must be an employee of, or affiliated with, an approved Agency/Provider Association operated or certified by OPWDD or other organization associated with the OPWDD service system.

To present the *Supporting Person Centered Outcomes: An Introduction to Person Centered Planning* training, instructors must have a minimum of two years of Medicaid Service Coordination work experience, or in another title with comparable working knowledge of Medicaid Service Coordination.

In addition instructors must also have experience in development of *or* facilitation of Person Centered Plans *and* knowledge of Person Centered approaches *or* different Person Centered Planning methodologies. **Individualized Service Plan development alone does not meet the criteria standards for development or facilitation of Person Centered Plans.**

Instructors must be permitted by their agency sufficient time to participate in the requirements of this role.

Instructors must regularly monitor OPWDD's online curriculum for updates. The Instructor or the Instructor's agency is responsible for retaining the signed, original sign-in documents for a period of six years from the date of training

**If you have any questions, please contact OPWDD Talent Development and Training at 518-473-1190.**





*Suggested duration for this course is 3.5 Hrs*

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**Communication Activity 2**

Participant Feedback: How can you use the information learned today to further support people?

**Symbol Legend:**



Prepare for next slide



Activity



**SUPPORTING PERSON CENTERED OUTCOMES:**  
An Introduction to Person Centered Planning

**TRAINING AGENDA & TRAINER’S TIMELINE**

|            | TOPIC  | APPROXIMATE<br>TIMELINE |
|------------|--|-------------------------|
| <b>I</b>   | Instructor(s), Participant Introductions and Background, Overview of Training Purpose and Objectives   | 10 minutes              |
| <b>II</b>  | Introduction of Person Centered Planning Philosophy  | 15 minutes              |
| <b>III</b> | The Planning and Discovery Process <ul style="list-style-type: none"> <li>• Communication Activity #1</li> <li>• Values Clarification Exercise</li> <li>• Hallmarks of Person Centered Planning</li> <li>• Performance Outcome Measures</li> </ul> | 60 minutes              |
| <b>IV</b>  | DVD: It’s Never too Early; It’s Never too Late   | 20 minutes              |
| <b>VI</b>  | The Tools and Tasks of Personal Futures Planning <ul style="list-style-type: none"> <li>• Graphic Mapping Exercise (<b>optional</b>)</li> </ul>  | 60 minutes              |
| <b>VII</b> | Identifying Risks and Developing Appropriate Safeguards  | 30 minutes              |
| <b>VII</b> | Training Summary/Conclusion <ul style="list-style-type: none"> <li>• Communication Activity #2</li> <li>• Participant Feedback: How can you use the information learned today to further support people</li> </ul>                                 | 15 minutes              |



## Instructor Guidelines

### Format:

- Three and a half (3 ½) hours of training.
- The training is conducted utilizing lecture, group interactive discussion, and experiential activities.

### Objectives:

Upon completion of this training, participants will be able to articulate:

- The philosophy and principles of person centered planning.
- The fundamental characteristics shared by person centered planning methodologies.
- How the “mapping process” supports a person centered approach to planning.
- How to support self determination and self direction in a person centered environment.

### Participants will also be able to:

- Identify the basic core values important to all people and how these core values relate to an individualized, person centered planning process.
- Identify the eight essential hallmarks of person centered planning.
- Use person centered planning to identify outcomes important to the person and their individual needs, life goals, strengths, abilities and interests.
- Identify the 21 personal outcome measures as defined by the Council on Quality and Leadership that relate to true personal and informed choice.
- Identify potential risks and strategies to work together to develop appropriate safeguards that will help support safe conditions for individuals, staff and communities.

### Audience:

- Service Coordinators
- Service Coordination Supervisors
- Support Brokers and others interested in facilitating person centered plans
- Individuals and family members interested in understanding the principles of person centered planning
- Organizations interested in creating Person Centered cultures



**Materials Needed:**

- Participant Manual
- Flip chart/Easel or Whiteboard
- Markers/Tape
- Fine Tipped Colored Markers – (red, green, blue, yellow & black)
- PowerPoint Presentation

**AV Equipment Needs:**

- Computer and LCD Projector
- TV and DVD player
- DVD: *It's Never too Early, It's Never too Late*

**Trainer Note:** It would be advantageous for you to review the DVD before conducting this training.



**SUPPORTING PERSON CENTERED OUTCOMES:**  
An Introduction to Person Centered Planning  
**List of Participant Manual Resources (PMR)**

- Page 1: General Background Information on Person Centered Planning
  
- Page 5: Training Agenda
  
- Page 6: The Principles of Self Determination
  
- Page 7: Examples of System Centered vs. Person Centered Thinking
  
- Page 8: Communication Exercise #1
  
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- Page 10: Eight Essential Hallmarks of Person Centered Planning
  
- Page 13: Personal Outcome Measures
  
- Page 14: A Road map of the Journey  
The Tools and Tasks of Personal Futures Planning
  
- Page 15: The Discovery Profile
  
- Page 16: Relationship Mapping Exercise
  
- Page 17: Communication Exercise #2
  
- Page 18: John’s Profile
  
- Page 31: PCO PPT Handout / Joe’s Maps (facilitated by Sandy)



## **INFORMATION ABOUT THIS INSTRUCTOR'S MANUAL**

This Instructor Manual is designed as a resource for trainers to learn and understand the philosophy of person centered planning (PCP) with a focus on outcomes. The guide is designed in a sequential learning format beginning with an understanding of the philosophy and value basis of person centered planning, thereafter participants will engage in a number of experiential exercises to learn process steps needed in order to help develop Individualized Service Plans (ISP) for individuals seeking greater choice and control of their lives.

This training is divided into three segments. The **first segment** provides an overview of the philosophy and principles of person centered planning. Four focus areas are addressed that explore and discover why it is essential to use person centered planning as a tool for service planning and plan development. Experiential exercises are employed to help discover meaningful life choice directions and expectations for all people, including people with intellectual and developmental disabilities. The process focuses on one person at a time. Exploration and discovery will come to light for participants through the three exercises below:

1. How does your daily morning routine relate to the morning routines of individuals with developmental disabilities?
2. What universal core values are important to all of us?
3. What general hallmarks define a person centered approach to planning?

The **second segment** of the curriculum provides methods and tools to understand ways to help an individual create an outcome-based plan which focuses on his or her goals, skills, needs, history and vision. Recognition of what the person is able to do and what they already bring to the table is paramount to creating a person centered plan that is



meaningful to the person. Another perspective may come from the contribution of others who know the person and are able to convey about what is possible or may be possible for that person to achieve. Together, what the person indicates and what others reveal, make up what is plausible i.e. what to pursue regarding future capacities and skill acquisition for that person. These pieces (i.e. maps) combine together to form a clearer picture of the person and what they want to achieve. This shared process is critically important in the development of individualized plans with outcomes that support the life goals, skills and positive vision for the person's future.

**Segment three** explores issues related to how risks are addressed for individuals in the planning process. Identifying person centered supports and services are obviously the correct approach to plan development, however it is necessary to also ensure that a plan has every chance to succeed. This includes understanding areas within the plan where risks may be prevalent and developing safeguards to mitigate them. Understanding risk potentials help to ensure that supports and services designed with the individual are addressed and strategies are developed to decrease the potential of harm to the individual, their staff, and the community at large. Not accounting for potential risks before proceeding with a service plan is a disservice to the person and diminishes success for the outcomes that the person is trying to achieve. Having an eye on potential risk factors throughout the entire discovery planning process serves to clarify what may work and what may not work for that person; thereby preventing many unwanted outcomes.



## **GENERAL INFORMATION about PERSON CENTERED PLANNING**

Overall, person centered planning (PCP) is a lifestyle discovery process used to search out what is truly important to and about a person and what capacities and skills that individual possesses. It is value based with the contention that each and every individual has unique capacities and skills. It focuses on a positive vision of the future for a person based on his or her strengths, preferences and capacities for acquiring new skills, abilities and attributes. It focuses on what a person can do versus what a person cannot do. A step-by-step process by a trained facilitator is used to help gather relevant information about a person. Each process step contributes to discovering a fuller picture of that person.

Person centered planning also identifies the various needs of an individual (e.g. habilitation needs, health care or behavioral needs, etc.) and strategies to address these needs. These strategies may be related to staffing supports, service needs, or met by natural or generic supports that exist in a person's life. The process serves to identify what is needed to create supports and services to meet the individual's needs and helps to support their direction to a quality of life that is productive and meaningful to them.

The individual is always at the center of the person centered planning process and the individual is as involved in the planning process as they are able. The person centered planning process is best accomplished with others who know and care about the person. A group engagement process explores the most important components of a person's current life, past history and future to formulate directions to take. It is very important to bring together people from various aspects of a person's life that know and value the individual. The discovery process emphasizes active listening with a focus on capacities, skill identification, and acquisition.



Working together with unified focus, a short and long-term vision for the person's life is developed and ultimately put in place for the person to explore and learn what works for him or her. A person's true life path takes not one but many paths. Discovery does not happen once but reoccurs with each new capacity, new relationship, and new direction.

It is important not to abbreviate or simplify the person centered planning process, every element of the process is vital to real Person Centered planning. Once fully complete, the resultant person centered plan is not a finished product, instead, the plan needs to change and adjust with and for the person over time. Consequently, it is necessary to revisit the plan periodically (at least once a year) to revise, amend and qualify what works and what new paths to take. In revisiting the plan, greater understanding and discovery is achieved. These changes and modifications are similar to pathways that all people make each and every day.

There are a number of person centered planning methodologies. Although the techniques may differ, the fundamental philosophies and principles are the same. Personal Futures Planning, Making Action Plans (MAPS) and Planning Alternative Tomorrow's with Hope (PATH) are some versions of Person Centered Planning where graphics are employed to capture the discovery process. These graphic pictures are referred to as maps. Marsha Forest began using the mapping process in the 1980's in an effort for people with developmental disabilities to more actively participate in the discussion, particularly as a better and more transparent way to understand and visualize the interactive process. As the saying goes "A picture is worth a thousand words". The visual use of maps, help everyone understand and capture what takes place. Pictorial maps assist in bridging communication gaps for everyone participating in the meeting and can be especially worthwhile for people with developmental/intellectual challenges. Instructional guidance and experiential exercises are provided in this training on how to create and use these



maps to inform an individualized service plan (ISP). Some people find graphics development easy whereas others find it more challenging. In either case, practice makes for better graphic mapping. Multimedia techniques are also becoming more popular in the development of person centered plans; including translating plans into personal PowerPoint presentations, portfolios and/or onto iPads.

**Trainer Note:** This general information is also included in the Participant Manual.



# SEGMENT 1: Understanding Person Centered Planning and the Discovery Process

## A. WELCOME, INTRODUCTIONS & OVERVIEW OF TRAINING 10 minutes

- OBJECTIVES:
- A. Introduction and welcome of participants to the training
  - B. Introduce trainer(s)
  - C. Review of training objectives

MATERIALS NEEDED:

- Participant Manual Resource (PMR): pgs 1-3: General Information
- PMR pg. 5: Training Agenda

|                                      |   |
|--------------------------------------|---|
| Welcome participants to the training | <p><b>Trainer Note:</b> The title slide  (PPT-#1) can be displayed as people register. This often helps ensure that guests are attending the appropriate training.</p> <p><b>WELCOME</b> each participant to the training  (PPT-#2). <b>ASK</b> participants to provide their job titles, length of time with their current agency and/or working in the field of developmental disabilities.</p> |
| Introduction of the trainer(s)       | <p>Trainer(s) <b>INTRODUCE</b> yourself and provide brief background; emphasizing qualifications and/or experiences related to person centered planning (PCP).</p> <ul style="list-style-type: none"> <li>• PMR pg. 6: The Principles of Self Determination</li> <li>• PowerPoint (PPT) Slides: #1 -# 7</li> </ul>  |



|  |   |
|--|---|
| <p>Review of Training Objectives</p>       | <p><b>INFORM</b> participants that:</p> <ul style="list-style-type: none"> <li>• The purpose of this course is to emphasize the values of Person Centered planning and to provide an overview of important tools related to the planning process.</li> <li>• This training will provide learning experiences to assist in the development of service plans to promote better lives for individuals with developmental disabilities.</li> <li>• We will discuss dignity of risk and developing strategies to address safety concerns to ensure a successful person centered planning process.</li> <li>• General background information on person centered planning is also included in their Participant Resource Manuals (PRM), pgs. 3-5.</li> </ul> <p><b>REFER</b> participants to PRM-pg 6 to review the full agenda and objectives (PPT-#3) for the day. This training is divided into three segments (PPT-#4).</p> <p><i>Segment 1:</i> The philosophy and principles of person centered planning.</p> <p><i>Segment 2:</i> Planning process, methods, and tools used to reinforce person centered outcomes.</p> <p><i>Segment 3:</i> Discussion on risk and the development of safeguards in the person centered planning process.</p> <p><b>INFORM</b> participants that this training has been designed to foster interactive discussion, through specific activities and sharing of experiences. The expectation is that participants will walk away with strategies that can be used immediately to assist the individuals they serve in developing individualized service plans that are truly person centered.</p> |
| <p>OPWDD from a Historical Perspective</p> | <p><b>Segment 1: Understanding Person Centered Planning and the Discovery Process (PPT-#5)</b></p> <p><b>INFORM</b> participants that we will highlight some significant OPWDD history to help them understand the various paradigm shifts of the agency over time.</p>   |

- OPWDD is an independent government agency whose primary purpose is to provide supports and services to individuals with intellectual and developmental disabilities and their families.
- Prior to July 2010 the NYS Office for Persons with Developmental Disabilities (OPWDD) was called the Office of Mental Retardation and Developmental Disabilities (OMRDD). Advocates across the nation objected to the stereotypes associated with the term “mental retardation” and almost every state in the nation has dropped these words from their agency name.
- Our mission is to “help people with developmental disabilities lead richer lives.” This means lives that are richer, meaningful and productive to the person, not what OPWDD deems to be meaningful and productive for them.
- It has taken many years of hard work and advocacy for self advocates and their families to enjoy many of the choices and freedoms they do today and there is still a long way to go. However, it is important to understand the history behind the work we do today as it will help improve the future for those we support.

Some major transitions in OPWDD’s history and service delivery system include  (PPT-#6):

#### A) The Institutional Age:

- In 1967, over 27,000 persons with developmental disabilities lived in institutions in New York State. These institutions were created as there were no community resources to support individuals with ID/DD. Despite many good intentions and well-meaning staff, the institutions were often overcrowded and understaffed.
- In 1972 the television documentary was written and narrated by Geraldo Rivera revealing extremely undesirable living conditions at Willowbrook State School in Staten Island.
- In 1972, parents of 5,000 persons who lived at Willowbrook filed suit in federal court over the unacceptable living conditions at the facility and the Willowbrook Decree was signed in May of 1975; which was NYSs commitment to improving community placements for those known as the



“Willowbrook Class”. This same philosophy was extended to all people we serviced. Willowbrook wasn’t officially closed until 1987.

**TRAINERS:** Canvass participants to determine if any worked for or remember the institutional age and how we served individuals during that time. Some appropriate responses may include:

- During this time, supports were somewhat custodial in that the objective was still to ‘take care’ of people we served. This was often referred to as a ‘maternal’ or ‘paternal’ mindset with staff feeling the need to ‘take care’ of people in our system. The service system was very often treatment oriented and there was a lot of concentration on how to ‘fix’ behaviors and outbursts rather than a determination of what may have caused those behaviors and outburst.
- Whatever supports and services were needed (such as medical, hair care, etc) were either provided by staff within the institution or brought into the institutions from the community for said purpose only. It was a highly segregated setting.

#### B) Community Residence/Community Presence

- In 1972, the first community residence for persons with developmental disabilities was opened in New York State.
- In 1974, the state institutions were renamed "Developmental Centers".
- In 1978, over 16,000 persons resided in these developmental centers; 7,000+ persons lived in community residences and over 22,000 persons received day treatment services. OPWDD (formerly OMRDD) was providing supports to more than 42,800 people.
- In 1983, OPWDD served 45,700 people; approximately 11,700 persons in developmental centers; 12,000 persons living in the community and about 30,000 individuals receiving day services.
- In 1988, OPWDD supported 16,000 persons living in community residences, about 15,000 families were receiving Family Support Services to assist them in supporting their loved ones at home, about 9,240 persons were living in

developmental centers and 38,000 receiving day treatment. More than 66,200 people were then being served.

**TRAINERS:** As deemed appropriate, emphasize the progression from developmental centers to community living supports using the information above.

**TRAINERS:** Again canvass participants to determine in any worked for or remember the institutional age and how we served individuals during that time.

- Although there was a significant move to community settings, many of the residential settings were still large and individuals often still were segregated from the general community.
- This was a time when programs for people with ID/DD were developed (e.g. Family Support Services Program, Senior Companions Program, Supported Work Program and we became more system-centered in our approach to serving them.

C) Self Advocacy and the Promotion of Individualized, Person Centered Approaches to Planning and Service Delivery:

- In 1986 the Self-Advocacy Association of New York was founded to assist local groups and individuals with developmental disabilities as well as help familiarize legislators and public officials with issues related to independent living, personal choice and program flexibility.
- Plans for the closure of Developmental Centers also began in 1986.
- In 1991, New York's first Home and Community Based Services (HBCS) waiver was approved. This **waiver** allowed persons to receive certain Medicaid-funded services while living in the community. The Waiver would subsequently become a central component of the Individualized Service Plan, case management and other parts of person-centered planning.
- In this year the Self-Advocacy Association also held its first statewide seminar representing the coming of age of growing consumer empowerment movement in New York State.
- In 1996, self advocates approached the OPWDD Commissioner requesting to begin exploring and incorporating the



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philosophy of “self determination” into OPWDD’s service system. This philosophy included an option for self advocates to self direct some or all of their supports and services. Our system truly began to move in a more person centered way.

**TRAINER:** **ASK** participants to share their thoughts on the growth of our service system over the past 45 years. **SHARE** and **REVIEW** with PRM-pg7 entitled *The Principles of Self Determination*.

**TRAINER NOTE:** Take a moment to reiterate key learning points from this discussion. Segway to next section: *Person Centered Planning Philosophy*.

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## SUPPORTING PERSON CENTERED OUTCOMES: AN INTRODUCTION TO PERSON CENTERED PLANNING

### TRAINING AGENDA

| <b><u>TOPICS</u></b>  |
|---|
| <b>INTRODUCTIONS</b>  |
| <b><u>SEGMENT 1:</u></b><br>Understanding Person Centered Planning and the Discovery Process <ul style="list-style-type: none"><li>• Introduction to Person Centered Philosophy</li><li>• The Art of Communication: Communication Activity #1</li><li>• Values Clarification Exercise</li><li>• Hallmarks of Person Centered Planning</li><li>• Personal Outcome Measures</li></ul> |
| Break   |
| <b><u>SEGMENT 2:</u></b><br>The Tasks and Tools of Person Centered Planning <ul style="list-style-type: none"><li>• DVD : <i>It's Never too Early, It's Never too Late</i></li><li>• The Tools and Tasks of Personal Futures Planning</li></ul>   |
| <b><u>SEGMENT 3:</u></b><br>Identifying Risks and Developing Appropriate Safeguards <ul style="list-style-type: none"><li>• Understanding Risk and Using Collaboration to Develop Appropriate Safeguards</li></ul>  |
| <b>TRAINING SUMMARY/CONCLUSION:</b> <ul style="list-style-type: none"><li>• Communication Activity #2</li><li>• Participant Feedback: How can you use the information learned today to further support people</li></ul>   |



**THE PRINCIPLES OF SELF DETERMINATION**

Defined by the Self Advocacy Association of NYS (SANYS)

|                           |   |
|---------------------------|---|
| <b>FREEDOM:</b>           | The ability for a person with a disability, along with freely chosen family and friends, to plan their own lives, with necessary support, rather than just purchase a program.  |
| <b>AUTHORITY/CONTROL:</b> | The ability of a person with a disability to control a certain sum of money in order to purchase supports.  |
| <b>RESPONSIBILITY:</b>    | The ability to arrange resources and personnel – both formal and informal-that will assist a person with a disability to live a life in the community that is rich in social associations and contributions.  |
| <b>SUPPORT:</b>           | The acceptance of the valued roles how a person with a disability wants to be a part of their community, such as through competitive employment, organizational affiliations, spiritual development and general caring for others in the community. |
| <b>SELF ADVOCACY:</b>     | The ability for a person with a disability to speak up for themselves, expressing their needs and wants.  |



**B: PERSON CENTERED PLANNING PHILOSOPHY**

**15 minutes**

- OBJECTIVES:
- A. To understand the philosophy and principles of person centered planning with a focus on outcomes.
  - B. To understand the values and characteristics shared by various person centered planning methodologies.

MATERIALS NEEDED:

- PMR pg. 7: System Centered versus Person Centered Thinking
- PPT Slides: #8- #11

Understanding the concept of “Person Centered Planning”

**ASK** participants what their perceptions of what is meant by “person centered planning”. **ALLOW** for responses. Some responses may include:

- It is about the person
- It is about what the person wants
- It focuses on what people can do instead of what they can’t
- The person is the focus of the process.
- It allows the person to make their own choices.

**SHARE** Some background information on Person Centered Planning  (PPT#8-#9):

- Person centered planning is not a new concept. It is a method of planning for people with disabilities that puts the focus directly on the person’s interests, strengths and capabilities.
- As formerly discussed, for people with developmental disabilities and their families, making life decisions about essential activities can be complex. Often when we look at a person's life, we see that the individual often lives in a setting which is not truly his or her home, usually engages in segregated activities with many other people with developmental disabilities, and often spends little or no time in community based activities.

- Previous planning activities for people with



developmental disabilities focused on assessing what deficits a person had and creating goals and activities to remediate those deficits. Often this type of planning has taken place without the person actually participating in the process.

- OPWDD has been adopting principles of person centered planning since the early 1990's; primarily as a tool for people interested in moving toward a lifestyle with more choice, community involvement, and self-direction. Unlike previous methods of planning, PCP does not focus on fixing or changing a person. Rather, PCP is about discovering the traits, skills, likes and dislikes of a person, and building on those things in forming a quality lifestyle for that person vs. a lifestyle built on their diagnosis and areas of deficit or treatment needs.
- Person centered planning places the person for whom planning is being done at the center of all activities. The person along with a group of interested individuals - chosen by the person - gather together to discover the person's skills, capacities and dreams for the future.
- Listening to what is said by the person and by each of the other people who know the person best is critical to gathering all relevant information available about that person.
- This is why the person centered planning process is often referred to as a "discovery process". Significant life defining directions are found through this discovery process.

**INFORM** participants that we will delve deeper into the discovery process throughout the course of this training.

- The person centered process helps to identify desired outcomes based on the individual's life goals, interests, strengths abilities, desires and preferences. The process helps to determine the supports and services that the

individual needs to work towards or achieve these outcomes and develop a plan that directs the provision of these supports and services accordingly.

- The person centered planning process also increases a person's capacity for “self determination”, “informed choice”, “self-advocacy”, and “self-direction”. These life defining directions provide the frameworks for operational supports for individuals we serve.
- Also important is the understanding that person centeredness is built principle of “Putting People First” which relates to ensuring that we truly listen to and adhere, using various strategies, to what they consider to be meaningful and purposeful for THEIR lives. This often calls for us, as professionals in the field, to put aside what we think could be important and meaningful to the person and work with the individual to discover what is meaningful to them and what supports they need to have lives as productive as they seek.
- This differs greatly from the system centered approach to planning previously used.

**REFER** participants to PRM-pg8  (PPT#10) to highlight differences between system centered and person centered philosophies.

**INFORM** participants that it is important to acknowledge that there are several methodologies for person centered planning. Some renowned individuals in person centered thinking and planning methodologies include: Michael Smull (Essential Lifestyle Planning), John O' Brien, Connie Lyle O'Brien (The Five Accomplishments), Beth Mount (Personal Futures Planning), Jack Pearpoint and Marsha Forest (Making Action Plans or MAPS) and others. Although their techniques may differ, each methodology is still based on the same fundamental philosophies and principles.



This training draws from the work and writings of many of these renowned individuals.  (PPT #11). However, when we look closely at an applicable person centered planning methodology in the second segment of this training, we will use Personal Futures Planning as our guide to the person centered process. OPWDD has had a unique opportunity to work closely with Dr. Beth Mount over many years in promoting person centered approaches for all people we serve and many staff within OPWDD as well as staff in various voluntary agencies is familiar with her techniques.

**ENCOURAGE** participants to take advantage of any opportunity to attend a presentation by any of the noted specialists identified above.

**TRAINER NOTE:** Take a moment to reiterate key learning points from this discussion. Segway to next section: *The Art of Communication*.



| <b>EXAMPLES OF SYSTEM CENTERED<br/>VS.<br/>PERSON CENTERED THINKING</b>  |  |
|--|--|
| <b>SYSTEM CENTERED</b>   | <b>PERSON CENTERED</b>   |
| <p style="color: red; font-weight: bold;">FROM</p>  <p style="color: green; font-weight: bold;">TO</p> |  |
| Treatment and Programmatic orientation to meet needs.  | Develop an individualized plan based on the person's strengths and interests as well as their needs.             |
| Programs are often segregated and only support people with intellectual/development disabilities   | Find new possibilities for person where they become regular members of their general communities.                |
| There is a focus on filling slots, beds and residential placements.  | Support people to live as independently in their homes and communities of choice.                                |
| People with disabilities are often stereotyped and "placed" with others who have the same diagnosis or Challenges.   | Support people to develop friendships with people they like or who they share something in common with.          |
| Regulations, Policies and Rules are used to govern people's activities   | More emphasis on the persons interests, dreams, and desires to lead meaningful lives and be productive citizens. |



**C. THE ART OF COMMUNICATION**

**15 minutes**

OBJECTIVES: A. To understand how we communicate with people and various techniques that support real communication.

MATERIALS NEEDED:

- PPT - #12
- PMR pg.8:  **Communication Activity**

|                       |  |
|-----------------------|--|
| Exercise Instructions | <p><b>INFORM</b> participants that a fundamental skill needed to ensure we are using a person centered approach to helping individuals and families understand the scope of their need and interest and determine what supports will best assist them is “<b>the art of communication</b>”.</p> <p><b>PREPARE</b> participants for a communication activity</p> <p><b>INSTRUCT</b> participants to turn to PMR pg8: <i>Communication Activity #1</i>, of the Participant Manual.</p> <p><u>Review exercise instructions:</u><br/>                 STEP 1: <b>ASK</b> everyone to identify a partner and communicate with each other the following scenario:  (PPT-12)</p> <p style="text-align: center;"><b>Recall the most meaningful thing you did in the past week or so. It does not have to be earthshaking, just something that was meaningful and memorable that you engaged in over the past week. Take 2-3 minutes to share your experience with your partner and then your partner will have 2-3 minutes to share their meaningful and memorable experience with you.</b></p> <p><b>INSTRUCT</b> partners are to ask no questions, just listen to what they are being told.</p> |
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STEP 2: After 5-6 minutes of dialogue, **ASK** some participants to share what they heard their partner share with them and **vise-versa**.

**ASK** participating partners:

- How much were you able to tell about your partner's likes and dislikes?
- Did you find out anything about the relationships important to them, activities they enjoy or contributions that were important to them?

STEP 3: **INFORM** participants that they need to remember who their partners were for this activity and the information discussed as we will be revisiting this exercise again later in the day.

**ASK** participants why communication is important to the person centered process. Answers may include:

- It helps you understand people
- It helps you understand what people want
- It enables you to better assist people to find the best supports to meet their needs

**SOLICIT** feedback from participants on what skills they feel are needed to communicate effectively with people we support. Answers may include:

- Patience
- Empathy
- The ability to listen
- Knowledge of our service system.

**ENGAGE** participants on strategies they feel let people know you are really communicating with them. Some strategies include:

- Using eye contact
- Using body language that shows you are engaged in the conversation; not bored by it or urging them to hurry things along
- Asking questions to get more clarity or information
- Smiling
- Using the individual's name



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**INFORM** participants that communication may seem simple, but it involves more than just talking. Learning to communicate effectively is a skill. Communicating effectively can help you understand people better, get a clearer perspective of the situations they may be facing, and enables you to help them with decision making. Effective communication can also cut down on misunderstandings and prevent conflicts. Effective and honest communication also helps to build trust. All these characteristics are essential in developing and implementing an individual’s person centered plan.

**TRAINER NOTE:** Take a moment to reiterate key learning points from this discussion. Segway to next section: *Values Clarification Exercise*.

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**COMMUNICATION EXERCISE #1**

**Have participants choose a partner and communicate with each other the following:**

**Recall the most meaningful thing you did in the past week or so. It does not have to be earthshaking, just something that was meaningful and memorable that you engaged in over the past week. Take 2-3 minutes to share your experience with your partner and then your partner will have 2-3 minutes to share their meaningful and memorable experience with you.**

**Partners are to ask no questions, just listen to what they are being told.**



**D. VALUES CLARIFICATION EXERCISE**

**15 minutes**

- OBJECTIVES:**
- A. To identify core values for people with developmental/ intellectual disabilities.
  - B. To increase participant knowledge of how to incorporate these important values into the person’s service plan.

**MATERIALS NEEDED:**

- PowerPoint Slides - #13 - #14
- PMR pg.9: Values Clarification Exercise,
- Flip chart, Easel or whiteboard for the instructor to record group responses

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|--------------------------------------|---|
| <p>Values Clarification Exercise</p> | <p><b>ASK</b> participants if they have ever participated in a values clarification exercise?</p> <p><b>INFORM</b> participants that they are about to examine their personal values and how they relate to universal core values for all people.</p> <p><b>INSTRUCT</b> participants to turn to PMR pg. 9, of their Participant Manual.</p> <p>Participant exercise instructions:  (PPT-13)</p> <p>STEP 1: Explain that the values clarification worksheet is a list of things that people value, they wish they had, they want to keep. There are 60 items identified in three rows. Ask participants to review the items and select their top ten most important values. Indicate that in choosing the top ten values participants are to think about what is most important to them? What makes them happiest? They are to circle the ten (10) words from this listing.</p> <p>Allow five to seven minutes for people to make their selections.</p> <p><b>Trainer Note:</b> As participants work through the activity, the instructor can count the number of participants in the room to prepare for additional steps in the activity process.</p> |
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STEP 2: Capture group responses. Read out loud each of the 60 values.  (PPT-14) Ask participants to raise their hand to indicate a value they have chosen. As each value is read, the instructor is to record group responses by counting the number of responses (raised hands) and writing in the total number next to the value listed.

STEP 3: At the completion of the recording, the instructor will review the totals for each value, determining the top ten (10) most frequently selected values for the group. This recording and counting process can be done on a separate piece of newsprint or whiteboard so participants can see the process.

(Instructor may solicit assistance from a participant in identifying the top 10 group responses.)

STEP 4: Ask the group to compare their personal values from those selected by group consensus.

STEP 5: From the 10 group responses, ask participants to categorize under central headings any values (items listed) that relate to one another. (ex: family, children, love, church can be grouped under the heading RELATIONSHIPS)

**Trainer Note:** Generally there are 4 key group headings that come out of this discussion. Trainers may help participants get here:

- **RELATIONSHIPS:** all people want to feel connected in some way whether it is to their families, friends, pets, or higher power;
- **SELF-SUFFICIENCY:** as all people want to know that they can do something for themselves; no matter how small;
- **CITIZENSHIP:** all people want to have the ability to contribute in a meaningful way to their lives, families, communities, or others; and



- **HEALTH** often makes the top 4 as well, but is a category that enhances the three areas above. The healthier one is, the more relationships they form and sustain; the healthier one is, the more they can do for themselves; and the healthier one is, the more productive they feel and the more contributions they can make to their families and communities.

### **Instructor Discussion Points:**

**The instructor should relate these universal points to participants:**

- These core values: Relationships, Self-sufficiency, and Citizenship are applicable to all people.
- Indicate that individuals we support share the same universal core values as do anyone else and that our purpose is to support people to lead productive lives. Also, to attain service plans in support of individual core values.

### **Important Note for instructors to emphasize:**

The identified core values from this exercise align with OPWDD's guiding principles: relationships, living in homes and communities of choice, work and other meaningful community activities and living a healthy lifestyle.

Remembering these core values when engaged in person centered planning and development is the best way to support people with developmental disabilities. The provision of supports is meant to help the person achieve the outcomes that are most important to them. These core values help to shape the goals and directions of the person's Individualized Service Plan (ISP). The effectiveness of a person centered plan of support can be determined by ongoing discussion with the person to determine if the outcomes areas most important to them are achieved from the supports in place.

**TRAINER NOTE:** Take a moment to reiterate key learning points from this discussion. Segway to next section: *Eight Essential Hallmarks of Person Centered Planning.*



## VALUES CLARIFICATION EXERCISE

What is most important to you? What makes you happiest? The following is a list of things that people value, things they wish they had; things they want to keep. Please circle the (10) words from this list that would be most important to YOU individually.

|                    |                          |                        |
|--------------------|--------------------------|------------------------|
| Self-reliance      | Food                     | Fame                   |
| Family             | Quality                  | Food                   |
| Independence       | Productivity             | Sex                    |
| Appearance         | Involvement              | Freedom                |
| Hobbies            | Love                     | Recreation             |
| Self-worth/Respect | Self-direction           | Animals/Pets           |
| Work               | Security                 | Home                   |
| Achievement        | Knowledge                | Peace                  |
| Acknowledgement    | Laughter                 | Right to grieve        |
| Health             | Money                    | Children               |
| Personal Goals     | Inclusion                | Retirement             |
| Space              | Preferences              | Contribution           |
| Creativity         | Participation            | Helping People         |
| Protection         | Senses                   | Try things out         |
| Learning           | Skills                   | Improvement            |
| Influence          | Intelligence<br>Attitude | Agreement              |
| Dignity            | Experimenting            | Support                |
| Acceptance         | Comfort                  | Agility/movement       |
| Optimism           | Faith/Church             | Responsibility         |
| Contentment        | Friends                  | Explore new directions |



**E. EIGHT ESSENTIAL HALLMARKS OF PERSON CENTERED PLANNING 20 minutes**

**OBJECTIVES:** A. To identify and understand the eight essential hallmarks which lead to an effective and successful person centered planning process.

**MATERIALS NEEDED**

- PowerPoint Slides - #15 - #17
- PMR pgs. 10-11: Eight Essential Hallmarks of Person Centered Planning

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| Using a Person Centered Approach to Planning          | <p>A distinction between "person centered planning" and a "person centered approach" to planning needs to be acknowledged.</p> <p><b>EXPLAIN:</b> Formal person centered planning (such as Personal Futures Planning developed by Beth Mount) prescribes the use of specific tools and techniques; such as a particular mapping process. Although everyone, with or without a disability, could benefit from a formal planning process, these processes are often time consuming and reserved for situations where a more intensive planning process is needed to identify specific or changing needs.</p> <p>Our service system should be person centered for everyone we serve and OPWDD has identified eight essential hallmarks to a person centered approach to planning that should be utilized for all. Each hallmark highlights indicators of performance to help you evaluate the degree to which person centered planning principles are used in developing a person’s plan of services.</p> |
| Eight Essential Hallmarks of Person Centered Planning | <p><b>INSTRUCT</b> participants to PMR pgs 10-11: Eight Essential Hallmarks of Person Centered Planning. Use PowerPoint Slides 15-17 to review the Hallmarks of Person Centered Planning. OPWDD has defined eight hallmarks essential to the success of the person centered planning process. Each hallmark has a set of performance indicators that help determine if you are truly moving in a person centered way.</p>  |



**DISCUSS** each of the hallmark indicators, noting how these indicators demonstrate that the hallmarks are effective and are actually occurring in people's lives.

**Note:** that when these indicators are absent, a person centered approach to planning is likely not occurring and as such services and supports may signify "system centered" service delivery versus person first services and supports.

**The eight essential hallmarks of a person centered approach to planning are:**

1. The person and people important to him or her are included in lifestyle planning, and have the opportunity to express preferences, exercise control and make informed decisions.
2. The person's routines, supports and services are based upon his or her interests, preferences, strengths, capacities and dreams.
3. Activities, supports, and services foster skills to achieve personal relationships, community inclusion, dignity and respect.
4. The person uses, when possible, natural and community supports.
5. The person has meaningful choices, with decisions based on his or her experiences.
6. Planning is collaborative, recurring, and involves an ongoing commitment to the person.
7. The person's opportunities and experiences are maximized, and flexibility is enhanced within existing regulatory and funding constraints.
8. The person is satisfied with his or her activities, supports, and services.

**PROMOTE** open discussion regarding each of the hallmark performance indicators. **Trainer Note:** you should be prepared to use, and are free to use, personal examples to illustrate any of the hallmarks.

Questions to promote discussion may include:



- Do identified themes result in supportive services and supports?
- How involved is the person centered planning team in ensuring person centered planning principles/values & tenets are achieved?
- Is the person's plan of services and supports individualized specifically for that person?
- Do the supports and services identified by and for the person help them work towards or achieve outcomes based on their needs, strengths, interests and capabilities?
- What degree of relationship building is part of the plan?
- What is the degree of natural and generic supports?
- Is the person making informed choices regarding important components of their plan?
- What amount of time is spent participating in community based activities of interest?
- Are participants resources allocated to supports and services identified as meaningful to that person?

**Trainer Note:** It is important to emphasize the fact that OPWDD has been moving towards a person centered environment for a number of years and that these elements were developed to help ensure that this culture shift is successful at all levels within the organization. This will also be further discussed later in the curriculum.



## **Eight Essential Hallmarks of Person Centered Planning**

- 1. The person and people important to him or her are included in lifestyle planning, and have the opportunity to express preferences, exercise control and make informed decisions.**

Indicators:

- The person and advocates participate in planning and discussions where decisions are made.
- A diverse group of people, invited by the person, assist in planning and decision making.

- 2. The person's routines, supports and services are based upon his or her interests, preferences, strengths, capacities and dreams.**

Indicators:

- The person's dreams, interests, preferences, strengths, and capacities are explicitly acknowledged and consequently their plan drives activities, services and supports.
- Services and supports are individualized and do not rely solely on preexisting models.
- Supports and services result in goals and outcomes that are meaningful to the person.

- 3. Activities, supports, and services foster skills to achieve personal relationships, community inclusion, dignity and respect.**

Indicators:

- The person has friends, and increasing opportunities to form other natural community relationships.
- The person has a presence in a variety of typical community places. Segregated services and locations are minimized.
- The person has the opportunity to be a contributing member of the community.
- The person can access community-based housing and work if desired.

- 4. The person uses, when possible, natural and community supports.**

Indicators:

- With the person's consent, the support of family members, neighbors and co-workers is encouraged.
- The person makes use of typical community and generic resources whenever possible.



**5. The person has meaningful choices, with decisions based on his or her experiences.**

Indicators:

- The person has opportunities to experience alternatives before making choices.
- The person makes life-defining choices related to home, work and relationships.
- Opportunities for decision-making are part of the person's everyday routine.

**6. Planning is collaborative, recurring, and involves an ongoing commitment to the person.**

Indicators:

- Planning activities occur periodically and routinely.
- Lifestyle decisions are revisited.
- A group of people who know, value, and are committed to serving the person remain involved.

**7. The person's opportunities and experiences are maximized, and flexibility is enhanced within existing regulatory and funding constraints.**

Indicators:

- Funding of supports and services is responsible to personal needs and desires, not the reverse.
- When funding constraints require supports to be prioritized or limited, the person or advocates make the decisions.
- The person has appropriate control over available economic resources.

**8. The person is satisfied with his or her activities, supports, and services.**

Indicators:

- The person expresses satisfaction with his or her relationships, home, and daily routines.
- Areas of dissatisfaction result in tangible changes in the person's life situation.



**F. PERSONAL OUTCOME MEASURES**

**10 minutes**

- OBJECTIVES:
- A. To identify personal outcome measures that help ensure the effectiveness of a person centered planning process
  - B. To understand how the Hallmarks and Personal Outcome Measures relate to OPWDD’s Mission and Vision Statements.

**MATERIALS NEEDED**

- PowerPoint Slides - #18 - #22
- PMR pg 13: Personal Outcome Measures

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| <p>OPWDD Mission and Value Statements</p> | <p>Person centered planning acts to improve the quality of life of the person who is the focus of this planning process. A person's quality of life becomes more fulfilling by building on the central personal preferences and lifestyle themes identified through a person centered planning process.</p> <p>Person Centered Planning experiences assist people to live lives in which they participate with peers, make meaningful contributions to their homes and neighborhoods, feel like productive citizens and are valued within their communities.</p> <p><b>REVIEW</b> the OPWDD Mission Statement:  (PPT-18) <b>“We help people with developmental disabilities live richer lives.”</b></p> <p><b>HIGHLIGHT</b> the four key concepts in the OPWDD Vision Statement: <b>People with developmental disabilities have the right to:</b></p> <ol style="list-style-type: none"> <li>1) <b>Enjoy meaningful relationships with friends, family and others in their lives,</b></li> <li>2) <b>Experience personal health and growth,</b></li> <li>3) <b>Live in the home of their choice, and</b></li> <li>4) <b>Fully participate in their communities.</b></li> </ol> <p><b>DISCUSS</b> common elements between OPWDD’s mission and vision statements, universal core values and the eight hallmarks of person centered planning.</p> <p>Collectively, these factors lead individuals we serve to lead</p> |
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|                                  |  |
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|                                  | <p>lives of quality and distinction.</p>   |
| <p>Personal Outcome Measures</p> | <p>As OPWDD continues to transform the system of supports for people with developmental disabilities, one significant measure of quality will be the outcomes for the person that are achieved by the supports in place.</p> <p>OPWDD has embraced the Council on Quality and Leadership’s (CQL) Personal Outcome Measures (POMs) as the person centered quality of life measurement that will be used as a critical quality measure as OPWDD transforms services.  (PPT-19) Personal outcome measures enhance the system to focus on quality from the perspective of the individual receiving services. It is anticipated that the POMs will help OPWDD to:</p> <ul style="list-style-type: none"> <li>• Ensure a more person centered system – meaning that supports and services will better match each person’s unique identified interests and needs, including opportunities for self-direction;</li> <li>• Serve people in the most integrated settings possible and in communities they choose to live;</li> <li>• Provide for better integrated, holistic planning and supports for individuals</li> <li>• Measure quality based on individualized outcomes.</li> </ul> <p>The Council and Quality and Leadership (CQL) developed a list of 21 personal outcomes designed to measure if the person is supported in a way that achieves the outcomes that are most important to them. POMs are a quality of life measure that is all about the person’s dreams. These outcome measures focus on a person’s uniqueness and evaluate the effect of the supports in place through the lens of the person.</p> <p>The use of the CQL POMs will be incorporated into the system over time. Today it is important to consider the outcomes most important to people receiving supports as</p> |



you plan in a person centered manner. Additionally, to determine if the plan is effective the 21 outcome areas identified by CQL should be considered.

**INSTRUCT** participants to turn to PMR pg.13: *Personal Outcome Measures*, of their Participant Manual to review these outcome measures and their correlation to the eight hallmarks and five accomplishments above.  (PPT-#20-22).

**TRAINER NOTE:** Take a moment to reiterate key learning points from this discussion. Segway to Segment Two: **Tasks and Tools:** *DVD: It's Never too Early, It's Never Too Late.*



## Personal Outcome Measures

Personal Outcome Measures focus on the choices people have and make in their lives. The Personal Outcome Measures developed by CQL are organized into 3 topic areas highlighted below:

### My Self

1. People are connected to support networks
2. People have intimate relationships
3. People are safe.
4. People have the best possible health.
5. People exercise rights.
6. People are treated fairly.
7. People are free from abuse and neglect.
8. People experience continuity and security.
9. People decide when to share personal information.

### My World

10. People choose where and with whom they live.
11. People choose where they work.
12. People use their environments.
13. People live in integrated environments.
14. People interact with other members of the community.
15. People perform different social roles.
16. People choose services.

### My Dreams

17. People choose personal goals.
18. People realize personal goals.
19. People participate in the life of the community.
20. People have friends.
21. People are respected.

From the Council on Quality and Leadership (CQL), 2005

\* Disclaimer: This training curriculum is NOT focused on educating people on the CQL process but for reviewing these outcome areas. This content is only meant to identify the important area for consideration in a person centered planning process.



## SEGMENT TWO: TASKS & TOOLS

### G. DVD: IT'S NEVER TOO EARLY, IT'S NEVER TOO LATE.

**20 minutes**

- OBJECTIVES: A. To demonstrate facilitation of the person centered planning process.  
 B. To demonstrate how outcomes are defined and implemented through the person centered planning process.

#### MATERIALS NEEDED

- DVD: *It's Never too Early, It's Never too Late*

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| Personal Experiences with the Person Centered Planning Process | <p><b>DETERMINE</b> if there are attendees who have participated in a person centered planning process before and ask them to share their experiences. Trainer may also ask these volunteers to share any differences they may have experienced between the person centered planning process and the Individualized Service Plan (ISP) process.</p> <p><b>INFORM</b> participants that we will be discussing the parallels between these two processes later in the training.</p>  |
| <i>It's Never too Early, It's Never too Late</i>               | <p><b>INTRODUCE</b> participants to the DVD entitled <i>It's Never too Early, It's Never too Late</i>, which is an overview of the basic framework of Personal Futures Planning developed by Beth Mount.</p> <p><b>Trainer Note:</b> As possible, review this DVD before conducting this training.</p> <p>Following the viewing of the DVD, a brief discussion should take place based on participant thoughts and observations of the video. <b>ASK</b> participants what they thought to be the most significant facilitation skill used by Beth Mount during the process. Were there things in the video that stood out that revealed the meaningfulness of person centered planning?</p> <p><b>ASK</b> if there are any participants who have participated in both the person centered planning process and the ISP planning process. If so, ask the participant to share their experiences.</p> |



Some comments may include:

- ✓ The person centered planning process is conducted with more input from the person than the ISP process seems to be.
- ✓ The person centered planning process is with the person not just about the person.
- ✓ Those who come to the person centered meeting are committed to the person and the timeline of the meeting.
- ✓ Often in an ISP meeting, people want to give their reports and move on to their next appointment.
- ✓ Goals are often written before the ISP meeting begins, but in the person centered planning process, the goals aren't defined or written until after the plan is developed.
- ✓ Individuals seem to communicate more, whether by speech, gestures, or assistive aides, during their person centered planning meeting. It is clear that the focus is on them.

**Trainer Note:** If no one in the class has participated in a person centered planning process, the trainer should be prepared to highlight some of the above or to pull from their own personal experiences to illustrate any similarities/ differences.

**TRAINER NOTE:** Take a moment to reiterate key learning points from this discussion. Segway to next section: *The Tools and Tasks of Personal Futures Planning*.



**H. THE TOOLS AND TASKS OF PERSONAL FUTURES PLANNING 60 minutes**

- OBJECTIVES:
- A. To understand person centered planning as a discovery process.
  - B. To demonstrate the six key stages of the Personal Futures Planning process.
  - C. To develop knowledge of and competency in this six stage process.
  - D. To link the stages of Personal Futures Planning to steps illustrated in the DVD: *It's Never too Early, It's Never too Late.*

**MATERIALS NEEDED:**

- PowerPoint Slides - #22 - #23
- PRM pg. 14: The Tools and Tasks of Personal Futures Planning
- PRM pg. 15: The Discovery Profile
- PRM pg. 16: The Relationship Mapping Exercise (optional activity)
- PRM pg.18-30: John’s Maps – The Profile
- PMR #31: Rob’s Plan facilitated by Sandy
- Optional: Flip chart, Easel or whiteboard for Relationship exercise

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| <p>Identifying the Six Tools and Tasks of Personal Futures Planning</p> | <p>As noted before, there are a number of methodologies that can support planning with people we support in a person-centered, individualized way. The principles of them all are basically the same, to support the person to determine, as much as they are able, the course of life that will meet their needs and interests and identify the supports needed to make this happen.</p> <p>The Personal Futures Planning process developed by Beth Mount is comprised of six key tasks. Each task provides a structure for organizing pertinent information about the individual that is engaging in this planning process.</p> <p>The six tasks are:</p> <ol style="list-style-type: none"> <li>1. Getting to Know People</li> <li>2. Finding Capacities in People</li> <li>3. Finding Opportunities in Community Life</li> <li>4. Creating a Vision for the Future</li> <li>5. Supporting People Over Time to take Action and Try Things</li> <li>6. Organizational Change &amp; Constructive System Supports</li> </ol> <p>Each task has a tool identified to help obtain the information necessary to meet the task.</p> |
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|   | <p><b>INSTRUCT</b> participants to turn to PMR pg. 14: <i>The Tools and Tasks of Personal Futures Planning</i>, of the Participant Manual to illustrate these stages.</p> <p>Personal Futures Planning uses graphic mapping to help provide a more complete picture of what the person wants and needs for his/her future. This was highlighted in the DVD that was just shown. The process used for gathering information to complete these ‘maps’ is often referred to as a ‘discovery process’.</p> <p><b>INFORM</b> participants that we will review each task separately.</p>   |
| <p>TASK 1:<br/>Getting to Know People</p> | <p>Task 1 is <i>Getting to Know the Person</i>. The objective is to identify what people are in the person’s life and their commitment to the person. The graphic tool identified is: <u>The Relationship Map</u>.</p> <ul style="list-style-type: none"> <li>• A relationship map helps you to discover the various relationships in the person’s life and how important and connected the person is to various people in their lives. The objective is to get as complete a list as possible of personal connections.</li> <li>• Often this determination begins by asking the focus person (i.e., the person for whom the planning is being done with and for) who they want to involve in their meeting.</li> <li>• Next you may ask for other significant family, friends, acquaintances and staff that the person would like to participate in their planning meeting.</li> <li>• In some instances accessing the person’s historical record may provide some insight; however information about a person and aspects of the person's life is often not obvious from a person's clinical history. Consequently, you seek to bring together those people who have had direct contact with that person to piece together a more complete picture of who that person really is. In fact many person centered planning facilitators do not review a person’s clinical records</li> </ul> |

before beginning the planning process as this can often influence perceptions and unconsciously guide discussions.

These relationships are often 'mapped' out in a way that helps identify who the person feels they have close relationships to as well as others who may have lesser, yet still significant roles in their lives.

It is very important to include as many relationships as possible, including people from the past, and people on the "outside edge" of the focus person's life. Also identify people who have various roles in people's life, (for instance school friends or teachers, community connections, etc).

Relationships with people that the person may want to reunite with in the future can also be highlighted here. You may find new opportunities to strengthen and deepen these relationships.

Often the most interesting information about a person is contained in the folklore of the people who have spent the most time with him or her. Therefore, it is important to identify these people and, with the focus person's approval, seek to involve them in the planning process. This will enable you to get a more complete description of the person, their needs, capacities, challenges, and aspirations.

Through developing the relationship map, your first objective is to identify who is involved in the person's life and their commitment to the person. Some people listed on the relationship map are most likely those who will form that person's Circle of Support. The Circle of Support is a smaller number of people who want to stay involved and are committed to that person for the long term.

For individuals who have spent considerable time receiving services in certified sites such as an Intermediate Care Facility (ICF) or comparable facility, you may find the person has few unpaid relationships, little or no family ties, and little if any connections in the community. Their primary relationships may be with staff from various programs the person may



attend or staff who works closely with them in their residence - which often includes direct support professionals. These are people who may come out to support the person's planning process.

Also, if there is a significant lack of social connections, relationship building **may** become a top priority in the development of a plan. Remember, the plan is **person centered** and the intent is NOT to push unwanted relationships onto the person but to determine the type of relationships the person would like to have or renew and, once established, to develop strategies that will help the person to maintain these relationships.

**Trainer Note: OPTIONAL EXERCISES:**

1. It is often helpful to demonstrate the relationship map by demonstrating your own map for participants. You can use a personal example which you can highlight on poster board or white board.
2. Another option is to **USE** PMR-pg16: Relationship Mapping Exercise and provide participants the opportunity to create their own relationship map.

If option 2 used, ask participants if they found out anything about themselves through this activity that they hadn't previously realized. For instance: Do they have more connections with their husband's or wife's family than their own; Do they have fewer relationships overall than they would have previously thought, etc.?

TASK 2:  
Understanding and Finding Capacities in People

**INFORM** participants that Step 2 is focused on *Finding Capacities In People*. The tool identified is: The Discovery Profile.

This task focuses on engaging the person and their planning team in a planning and discovery process. This process helps lead to an understanding of the essence of the person. Through this process we seek relevant information about the person, looking for interrelated facets of the person's life. Mapping helps identify what is working for the person at present, what may have worked in the past and what needs to be put in place to help assure a successful and meaningful pathway for the future.

The compilation of these maps is called **THE PERSONAL PROFILE**. The Personal Profile identifies macro themes and interests of the person and information for future strategies.

In organizing the person centered planning process; we consider factors in three life stages. The personal profile maps can be broken down into these three stages.

**INSTRUCT** participants to turn to PMR #15 of their Participant Manual to discuss the Discovery Profile in more detail.

#### Talking Points about Developing a Personal Profile:

- In the first stage, we view what is going on in that person's life at the present time. We examine who is currently in that person's life, how they spend their time each day and where they go, and what their preferences are – both what they enjoy as well as what they don't.
- Next, we look back to their history & background, help to identify the capacities they have and what current and future goals/themes may be part of their life ahead.
- Finally, we look at all maps combined as mosaic pieces in development of a risk profile and safety plan to make possible his/her future while simultaneously protecting a person's safety and health.
- Many times you may need to add various maps to capture additional information that individualizes and influences the person's future. These areas may include: medical considerations, behavioral strategies, alternative communication strategies, community connections or other specialized areas.
- As depicted in the *It's Never too Early, It's Never too Late* DVD, the maps are often color coded using three major colors: Green to identify things that work for the person, Red to signify that something is not working, and Black or Blue to capture neutral yet still important information. Color coding maps helps everyone communicate more clearly.

**Trainer Note:** You can use John's Profile (PMR pgs. 18-28) to help



highlight these color distinctions and demonstrate how information is gathered and documented throughout the personal futures planning process.

It is important to remember that planning for a lifestyle that is satisfying, has growth potentiality and keeps up with everyday changes is a work in progress. Lifestyle changes occur each day, it is necessary to adjust and keep up with these changes. Fortunately, most adjustments are small and simple and do not require major shifts in how we live. What remains constant throughout these changes are the important relationships in our life, our health, what place we call home and lastly work and/or the meaningful activities we do. These central factors keep us steady in the face of a continuing changing landscape.

**Trainer Note:** Below is more detailed information on the most frequently used maps and how they are designed to help further create a holistic picture of the person's life.

### **Series #1: The Person's Life Now:**

The first sequence of this discovery mapping begins with looking at what makes up important elements of the person's life at the present time. These maps identify what is important and currently present in a person life.

- The first map in this series, the Relationship Map, defines who is or has been part of that person's life. **Trainer Note:** This information was covered in stage one) .
- Next is The Places/Daily Routines Map. This map details where the person goes each and every day from the time they rise to the time they go to bed. The Places/Daily Routines Map also captures information on where the person spends their time and how they participate in their community.
- The final map in this first grouping is The Preferences Map. This map looks at 2 facets; what works for the person - meaning what do they enjoy and want more of in their life, and what doesn't work for the person – what may frustrate them,

trigger inappropriate behavioral responses, or things they want less of in their life. The latter is often referred to as challenges or barriers.

**REMIND** participants that this information can be documented using color-codes Beth Mount demonstrated in the *It's Never too Early, It's Never too Late* DVD.

Taken together these maps give a perspective of a person's current activities and quality of life. Equally, these maps can also reveal things that do not add to the person's quality of life. These obstructive items are equally important to understanding a person's life

**Sequence 2: What is the person's history; what can he/she do and what is possible:**

The next series of maps capture what has already taken place in the person's life i.e. history/background, specific capacities or challenges they may have and, lastly, a culmination of what all the maps completed thus far reveal as most important about the person's life.

- The History/Background Map captures the person's life experiences from childhood until present. This map helps capture the experiences to date of the individual, but often the family as well. Often identified are positive experiences and accomplishments that have occurred in the persons' life that can continue to be built on. It may also identify significant losses or traumatic events that the person has gone through. Understanding these losses and traumatic events are often helpful in understanding the person themselves.
- Specialty Maps can be added to explore specific factors that may also influence the choices and planning with a person. For instance:
- A Health Map may be used for individuals who have health concerns that need to be taken into consideration for safe participation in their homes and communities. It is important to emphasize that these maps aren't designed to prevent



people from participating in their communities, but to ensure that these concerns are known and properly addressed with appropriate supports and services when the person is at home or in their community.

- A Behavior or Respect Map may be used to identify characteristics that may create barriers for community inclusion and community acceptance as well as strategies that may assist in keeping the individual, staff and community safe.
- A Communication Map is often essential for individuals who may not communicate verbally but use alternative communications such as picture books, gestures, or augmentative communication devices. This map may also provide strategies that will help others who don't know the person well to be able to communicate with the person as well.
- **Trainer Note:** In John's Maps, the respect and behavior maps were used to help develop his person centered plan to help understand reasons related to a specific behavior he exhibited (biting himself and others) and to discuss and develop strategies that could significantly decrease or eliminate this behavior as it was impacting his ability to access his community.

### **Series #3: The Person's Life Now:**

The next three maps focus on strategies for making the themes identified a reality for the individual. These maps relate more to planning for the person's future, what that future could look like, and strategies to get there.

- The Themes Map is the first map in this series. The themes map captures goals and themes of importance about that person and helps to signify directions of personal choice for the person's future. Themes are generally identified by topics or conversations that are continuously repeated throughout the development of the profile as areas of interest expressed by the individual and/or others who are participating in their



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|  | <p>planning process.</p> <ul style="list-style-type: none"><li>• There are two other maps in this series: <u>The Dreams, Hopes, and Fears Map</u> and the <u>Action Steps/Strategies Map</u>. We will discuss the Action Steps/Strategies Map in more detail as we review Task 5 of the Personal Futures Planning model.</li></ul>  |
| <p>TASK 3:<br/>Finding Opportunities in<br/>Community Life</p> | <p>Task 3 is designed to help individuals find or create community connections that align with their needs and interests. The tool identified is <u>The Community Map</u>.</p> <p>A Community Map plots connections within a specific radius of a person’s residential setting in an effort to connect them within their neighborhoods. For example, in NYC that radius may be 4-6 blocks whereas in Tupper Lake, NY that radius may be 30 miles.</p> <p>This third task helps to identify the various opportunities the individual can participate in within their chosen community. Through supports in one’s community provides the opportunity for the individual to become a ‘regular’; meaning that they are seen within their neighborhoods by their neighbors on a regular basis.</p> <p>This creates a sense of ‘belonging’ and ‘citizenship’; two of the core values we spoke about earlier. For some, the ability to navigate their community also supports ‘self-sufficiency’, a third core value. Therefore matching individual’s interests and capacities with community activities and associations often lead individuals to lives they consider to be meaningful and productive. It also provides others in their community the privilege and opportunity of meeting new people as well.</p> |
| <p>TASK 4:<br/>Creating a Vision for the<br/>Future</p>        | <p>Task 4 focuses on Creating a Vision for the Individual’s Future. The tool identified to support this step is <u>The Futures Map</u>.</p> <p>The futures map describes the major desires/wants/hopes a person has regarding his or her life ahead. If more clarity is needed on what these desires are, the <i>Dreams, Hopes, and Fears</i> map is available to help the individual and others participating in their planning process to identify what is most important to the individual in four major aspects of their life:</p>  |



- relationships they want to maintain or develop;
- where they want to live and who they want to live with;
- what they want to do with their day (vocational/educational); and,
- which community associations they would like to connect with.

**EMPHASIZE** how these four principles also align with OPWDD's vision statement.

The futures map defines directions and goals the person may want to experience down the road – 2 year intervals are often suggested for the futures map. This map captures the positive, long-term vision that the individual sees for their future and allows for creative planning by the individual and their circle of support to reach these goals.

A positive vision of the future is developed based upon information from the personal profile, a review of the theme map and what was identified by members of the person centered planning process.

The vision has both short term (two months) and long-term (two years) goals and directions.

These visions build upon trends and opportunities present in the environment, and the capacities, strengths, and preferences that form the basis of the themes. One such direction could be to self-direct one's supports and services. In NYS, Consolidated Supports and Services (CSS) is a HCBS waiver service designed to provide individuals with intellectual and developmental disabilities more control and flexibility over their supports and services by providing them with the opportunity to self-direct their supports and services and control their budget. Through self-direction individuals or their representatives have more control over the services they need, the staff or organization(s) that provides their services, and when and where these services take place.

Each OPWDD Regional Office has at least one CSS or Individualized Services Liaison. MSCs should be aware of this service option and the name of the appropriate Regional Office contact. The contact list can be found on OPWDD's website.

**Trainer Note:** For participants interested in learning more about self directed service options including CSS, or for those interested in becoming 'support brokers' can contact the CSS



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|  | <p>/Individualized Services Liaison at the appropriate OPWDD Regional Office. <b>Support Brokers</b> are specifically trained to assist an individual or family (on an individual’s behalf) who wants to self direct some or all of their supports and services to develop a self directed service plan. Regional Office staff can share information on specific responsibilities and training qualifications needed to fulfill this role.</p>  |
| <p>TASK 5:<br/>Supporting People Over Time to Take Action and Try Things</p> | <p>Task 5: <u>Supporting People Over Time to Take Action and Try Things</u> is supported by <i>Follow Along Meetings and Action Plans</i>.</p> <p>This step helps to move implementation of the plan forward and is a call to action by the individual and his or her circle members who are committed to working together as frequently as necessary, to review, adjust, discover and proceed with the steps necessary to achieve the goals identified on the Futures Map. This is often the hardest task of all as it requires commitment OVER TIME with a constant eye on the individual’s future vision.</p> <p>Meetings are often supported by a champion of the individual – a person who unequivocally believes in the individual’s vision. These meetings are usually known as circle meetings and the role of those who attend is to support the person in implementing the plan already developed.</p> <p>Not all who participated in the planning meetings will be regular members of the circle of support, but many can be called upon for their special expertise as the plan moves forward. Meetings are often facilitated and are designed to determine what actions have occurred, whether they were successful or not, and what the next steps are on the path towards their long term objectives. Creative visualization is essential. If you cannot visualize where to go you may not ever make the journey. People who succeed refuse to sit back and wait for things to happen. Activities are often captured on the <i>Follow Along Meetings and Action Plans Map</i>.</p> <p>Another way to incorporate outcomes derived from the person centered planning process is to coordinate the individual’s goals and the basic core values into the required ISP planning process. Existing ISP goals are not eliminated; but are enhanced based on this discovery process.</p> <p>This is the last stage in the mapping process under the direct control of individuals and families <b>BUT IT IS AN ON-GOING PROCESS.</b></p> |



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|  | <p>Through this last step, all persons committed to the individual continuously work towards supporting greater choice and independence. Although everyone involved in the person centered planning process may not be able to move to the fully integrated community setting, as a result of this process activities that are meaningful to the person and that align with their capacities and strengths will be incorporated in a way that will enhance their lives.</p> <p>We would be remiss not to acknowledge that there are often safety considerations and behavioral challenges that also need to be addressed in the planning process and there are times when individuals want to engage in activities that may present potential risk to the individual’s health and/or well being. These considerations should also be included in the planning processes. We will talk about this more in a few minutes.</p>  |
| <p>TASK 6:<br/>Organizational Change:<br/>Constructive System<br/>Supports</p> | <p>Task 6 is about <u>Organizational Change: Constructive System Supports</u>.</p> <p>This may be the last task in the personal futures planning process but the saying “Last but not least” is appropriate here. A person centered plan is more than just the mapping process. The plan must be implemented and to ensure successful implementation there must be support from the organization or organizations that are also supporting the individual and their personal vision.</p> <p>Agencies must for creative in ways to support individual’s interests and strengths. Without organizational support, implementing person centered plans are permanently stagnated.</p> <p>This is no easy feat for agencies, however as concern for individual’s health and safety is paramount for agencies. Promoting individualized, person centered services is quite a departure from traditional supports and services agencies have customarily provided over the past 25 plus years. It is often difficult for agencies to support practices that may seem risky to the health and safety of the individual as well as to the credibility of the agency. Applying strategies to support these life choices is the responsibility of all involved.</p> |



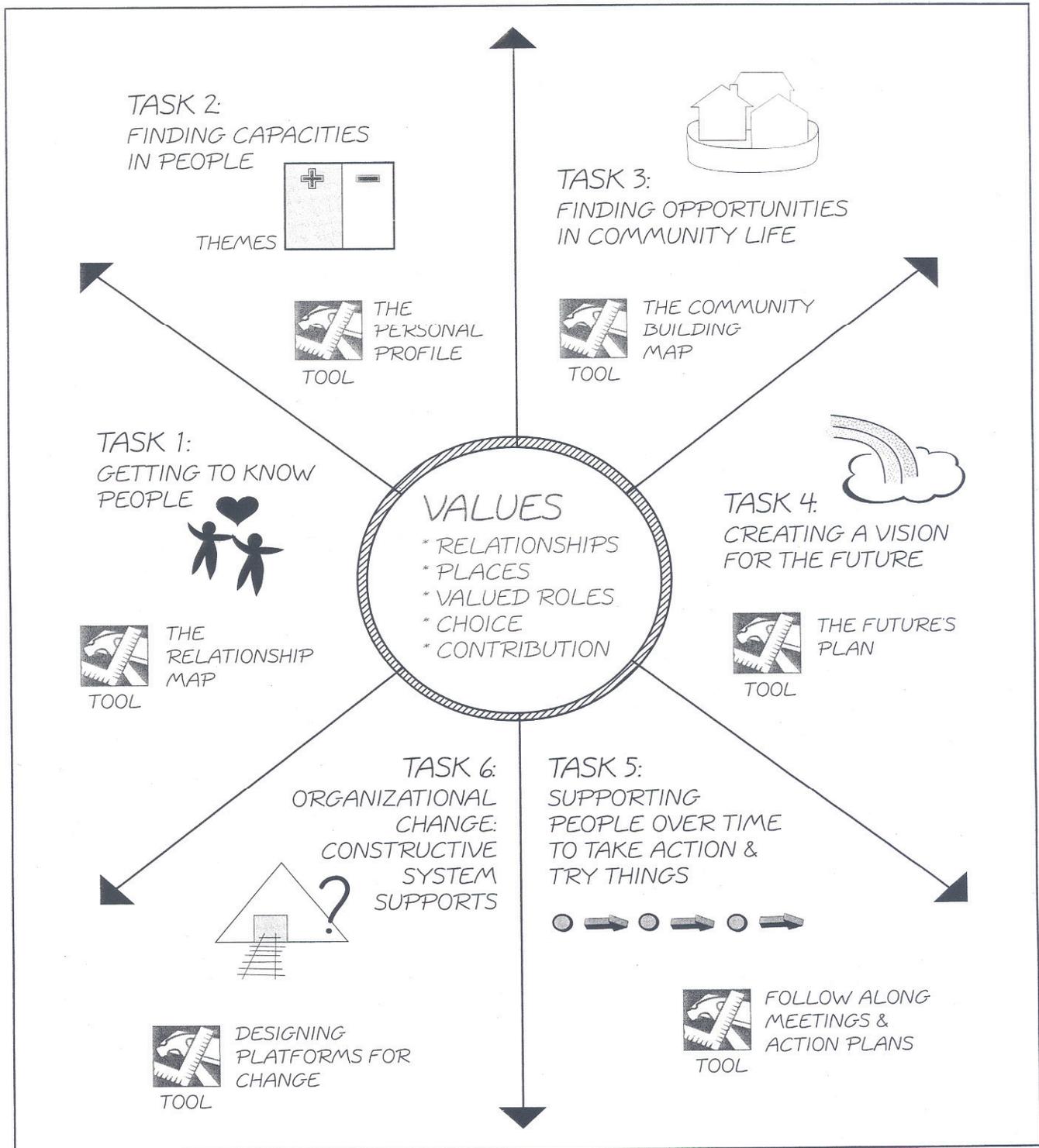
Commonalities in Person Centered Methodologies

**SHARE** with participants the story of Rob (PMR-31) who engaged in a person centered planning process with Sandy VanEck of Rensselaer ARC in his desire to have more control over his supports and services through an OPWDD HCBS Waiver Service called *Consolidated Supports and Services* or CSS.

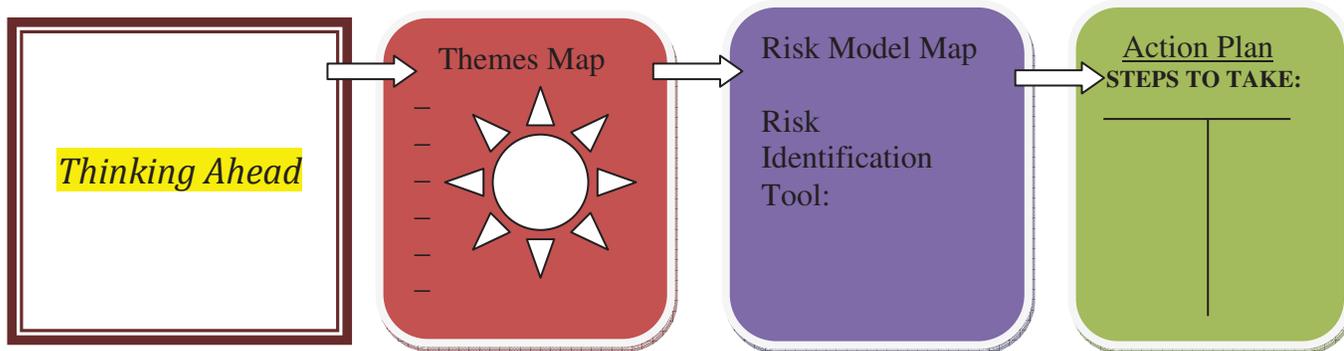
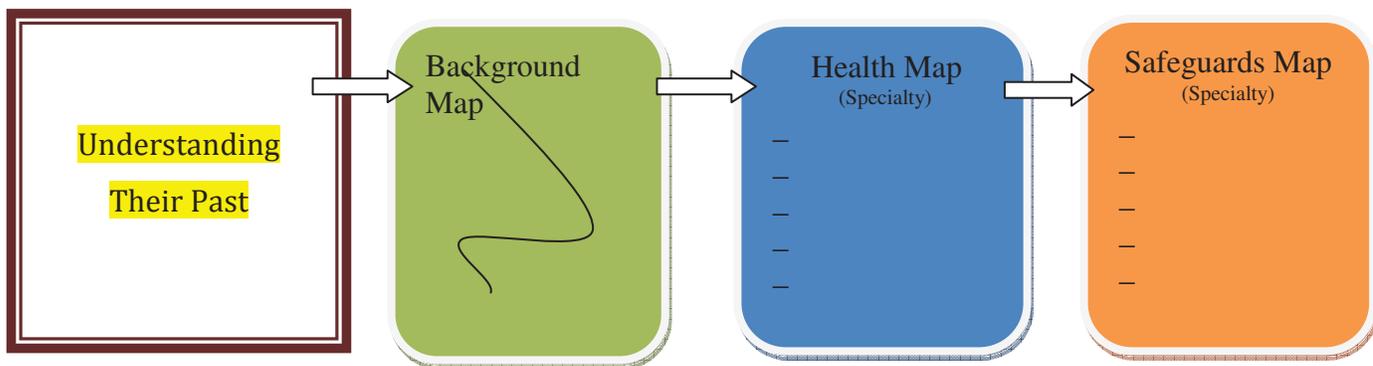
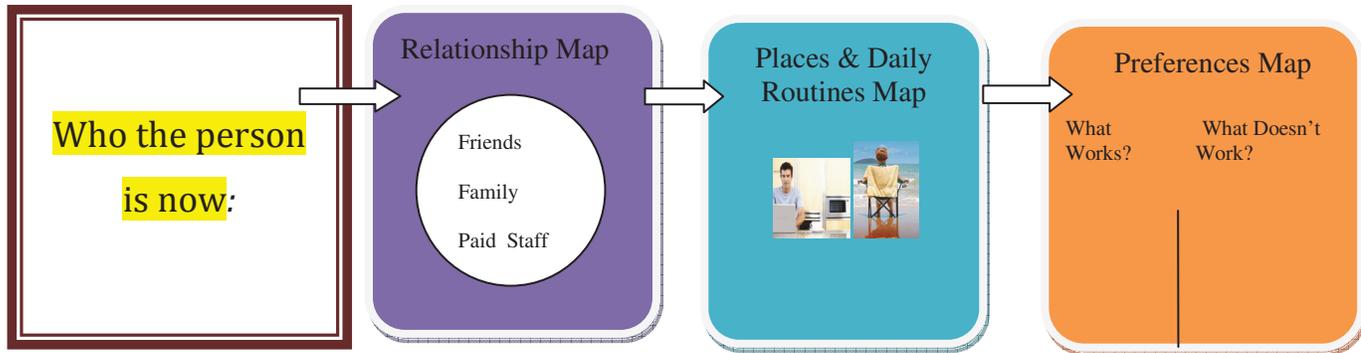
**NOTE** the common aspects in the planning process while acknowledging MAPS (Making Action Plans) as another person centered planning methodology to assist in developing this plan.

**TRAINER NOTE:** More specific information on Rob's plan is imbedded into his presentation attached. Then **take a moment to reiterate key learning points from this discussion.** Segway to **Segment Three: Risks and Strategies: *Understanding Risk and Developing Appropriate Safeguards.***

**A ROAD MAP OF THE JOURNEY  
THE TASKS AND TOOLS OF PERSONAL FUTURES PLANNING**



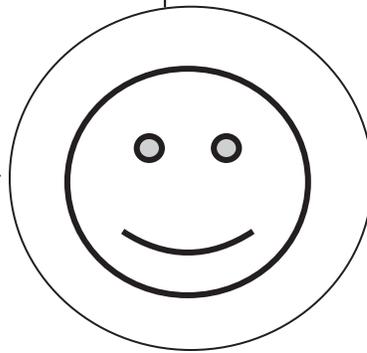
## The Discovery Profile



**RELATIONSHIP MAPPING EXERCISE**

FRIENDS

FAMILY



**PAID PROVIDERS**

## SEGMENT THREE: RISKS AND STRATEGIES

### I. UNDERSTANDING RISK AND DEVELOPING APPROPRIATE SAFEGUARDS 30 minutes

- OBJECTIVES:
- A. To understand the importance of risk related to personal growth.
  - B. To demonstrate a strategy that allows for all parties involved in the planning and implementation to work together in developing strategies to help ensure health and safety.

#### MATERIALS NEEDED

- PPT Slides: # 25 - #31

#### Understanding Risk



(PPT-25)

Throughout the person centered planning process it is necessary to identify and examine potential risks that the individual may be exposed to while pursuing his or her life objectives. Everyone has the right to make choices and with choice is a degree of risk potential.



(PPT-26)

Often risk has two sides – like a two-headed coin. On one side is the possibility of loss, injury, or disappointment; but on the other side of the coin, risk can be seen as the possibility for opportunity, success, and personal growth.  (PPT-27)

Some risks are non-negotiable, such as:

- Death
- Exploitation
- Injury, severe harm
- Violation of the law

Some are more subjective:

- Financial problems
- Isolation or loneliness

**ASK** participants: Is it possible to totally avoid risk? Allow time for responses which may include:

- No, we can never avoid all risks;
- The world is full of risks.
- It is not about how to avoid risks but how to manage risks.



(PPT-28) Taking risks often provides people the opportunity for personal growth. However, we can choose the degree of risk we expose ourselves to.

Examples of some common risks that people expose themselves to everyday include:

- Social risks: Being shunned by a community group or rejected by someone within the community.
- Personal risks: Consequences when choosing not to follow recommended supports or services, failure to take care of one's physical wellbeing or health care needs.
- Financial risks: The potential of losing money, sometimes significant amounts of money – losing one's home, family, friends, jobs, etc.
- Relationship risks: The possibility of not being liked, heartbreak, or feelings of loneliness.
- Employment risks: Failure to find work, difficulty getting to the work site; failure to perform the job functions appropriately, being fired from a job.
- Educational risks: Failing a class; failing to get the degree you are seeking.

Although there is no such thing as a risk free life, everyone involved in supporting individuals we serve must accept some level of responsibility for helping to mitigate potential risks.

Individuals with intellectual and developmental disabilities are often more vulnerable to risk. Some of these vulnerabilities may be very real while some are projected or anticipated based on assumptions and/or fears. However, whether real or perceived, all efforts must be made throughout the person centered planning process to identify potential risks and vulnerabilities (including behavioral and health considerations) and to work with individuals to develop meaningful, valid and appropriate



safeguards. The reverse means overprotection which prevents individuals we support from living the life they consider to be meaningful and productive.

Remember risk is often seen differently by various stakeholders. **USE** PPT-29 to demonstrate this example of John who wants to ride a motorcycle.

Informed choice and decision making means taking responsibility and understanding consequences of the decision you are considering. For people who have not had a rich experiential base in decisions and choice making; consequences and responsibilities represent important elements for exploration to each choice made. The term informed choice, which we reviewed earlier today, refers to a persons' knowledge of the consequence and responsibility of the decisions he/she is about to make. Therefore, people making choices need to understand more fully their responsibilities and possible consequences when making choices.

Through meaningful conversations with the person in a planning process the review of these areas where safeguards may be needed are not meant to be a deterrent to an individualized plan of support but an opportunity to identify approaches to support the person in a way that will mitigate or reduce the potential risks. Through thoughtful approaches to real life concerns, supports from both natural and paid support givers can be identified to help the person achieve the outcomes that are most important to them.

Collaborative Approaches to Developing Appropriate Safeguards

Collectively we must work together to help individuals identify any potential risks and/or vulnerabilities of a decision they want to make or a direction they want to pursue and to assist them to develop individually appropriate safeguards that will decrease or mitigate these risks.

Some risks are real, known, and understood by the individual and/or others who support him or her. Other risk can be real but have yet to be identified. The person centered planning process can help bring to the surface these unidentified vulnerabilities.

It is important to recognize that individuals are often hesitant to

speaking about their personal vulnerabilities as they fear that if they expose any weaknesses they won't be allowed the opportunity to pursue their individualized, person centered life goals.

This is a false presumption. Sharing these vulnerabilities helps to increase the success of a person centered plan. Understanding and addressing these issues increase the individual's potential for full, meaningful participation in community life and allows for the creation of appropriate supports and safeguards. This will help protect the individual, staff that support them, as well as the community at large and leads to the success of meeting their personal outcomes.

It is important to help individuals, and others who may be on their circles of support, appreciate the importance of sharing this information and how understanding potential vulnerabilities can enhance rather than restrict life opportunities. Not sharing this information can create larger, more detrimental vulnerabilities for all.

It is also important to emphasize that an identified risk or vulnerability in one domain of a person's life does not mean that this potential risk is assumed in other areas of the person's life. This is often a fear for individuals and even for family members that should be addressed and alleviated.

Identified risks may require the development of safety measures to help ensure the individual's safety and the plan's success. Identification of potential risks and development of safeguards are not the sole responsibility of the individual.  (PPT-30)

It is a collaborative process done in conjunction with the individual's Circle of Support which often consists of family members, friends and others; the agency providing the individual's services and supports and others who are committed to the individual's success. Proper identification and discussion of vulnerabilities will also assist individuals and those supporting them identify 'acceptable' risks; and provide ways in which they can support the individuals' opportunities for personal growth that all people seek. Therefore you also need to ask: (PPT-31) 

- What other supports are available to the individual?
- What role can the provider assume?
- What role can the family assume?
- What role can the circle of support assume?
- Is there a role that the community can assume or supports within the community that will support this individual?

Through thoughtful consideration and meaningful conversation among all relevant parties, which includes the individual, family members, natural and community supports as well as service providers, risks can be identified and often appropriate safeguards can be developed to help manage risk potential. These conversations can often be aided by informal and formal assessments of vulnerabilities, or checklists relevant to the individual's area of vulnerability.

**Trainer Note:** A potential quote and resource: "The purpose of any risk assessment (identification) is just as much about the happiness of the person as it is about their safety." (A Positive Approach to Risk Requires Person Centered Thinking, 2008; [www.helenandersonassociates.co.uk](http://www.helenandersonassociates.co.uk))

A safeguards map or plan should specify what the individual is seeking to accomplish, the positive goals and outcomes that will be achieved, what risks have been identified and what specific risks have been identified. Strategies should be developed that will set out explicit and justifiable rational for moving ahead and the plan should record who is responsible for ensuring various elements of the plan are successfully executed.

Having this collaborative team work together and using a group consensus process to develop these strategies gives more credence to the planning process and increases its' chance of success. This team should also be called upon to review the success of the strategies identified and to further modify these strategies if needed.

**TRAINER NOTE:** Take a moment to reiterate key learning points from this discussion. Segway to the final section: *Training Summary and Conclusion.*



**J. TRAINING SUMMARY AND CONCLUSION**

**15 minutes**

- OBJECTIVES:
- A. To determine how strategies shared in this curriculum helps lead to better communication and service planning.
  - B. To provide general recap and closure of the training session.

**MATERIALS NEEDED**

- PPT Slides: # 32-#33
- PMR-pg. 17

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| <p>Recap of the Day</p> | <p><b>ASK</b> participants to reconnect with their partner from the Communication exercise conducted earlier in the training. Using the same scenario below PMR-pg 17. <b>INSTRUCT</b> participants to communicate their experiences with one another. This time, allow the partner to ask any questions they feel will help them better understand the experience their partner is sharing with them.</p> <p style="text-align: center;"><b>Recall the most meaningful thing you did in the past week or so. It does not have to be earthshaking, just something that was meaningful and memorable that you engaged in over the past week. Take 2-3 minutes to share your experience with your partner and then your partner will have 2-3 minutes to share their meaningful and memorable experience with you.</b></p> <p>After 5-6 minutes of dialogue, <b>ASK</b> some participants to share what their experiences. Some questions you may pose can include:</p> <ul style="list-style-type: none"> <li>• Did you hear something significant that you didn't hear earlier?</li> <li>• Did you understand something that was important to your partner that wasn't clear to you in your earlier communication?</li> <li>• What strategies did you use from today's training that may have assisted in this communication exercise with your partner?</li> </ul> |
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**ALLOW** time for responses which may include:

- I really listened to my partner to understand why this experience was so memorable for him/her.
- I didn't know much about the activity my partner participated in until I asked some questions that helped me understand why it was important to him/her.
- I learned more about what interests my partner.

The strength in your communication with people you support will help you understand what is really important to them. These interests can then be incorporated into their service plans – enabling them to achieve personal outcomes that are meaningful to them.

**TRAINER NOTE:** Take a moment to reiterate highlights of the day.

**ENCOURAGE** participants to take what they have learned here today and begin to incorporate these principles in every conversation and every ISP or habilitation plan they create with people they support.

**THANK** EVERYONE FOR THEIR TIME AND ATTENTION.