



## **DEVELOPING EFFECTIVE PERSON-CENTERED PLANNING TOOLS & NEW JERSEY INDIVIDUALIZED SERVICE PLANS**

### **ABOUT THIS GUIDEBOOK**

This guidebook was developed as an informational resource for Support Coordinators to refer to as they facilitate the person-centered planning process and develop the Person-Centered Planning Tool (PCPT) and New Jersey Individual Service Plan (NJISP). It does not replace the training, instruction, and guided practice that is necessary for Support Coordinators (SC) to gain skills and competency, but rather is meant to complement training and reinforce concepts to further maintain the integrity of the person-centered planning process.

This guidebook reinforces basic information about person-centered planning in New Jersey, including guidelines to meet Medicaid requirements. An overview of each section of the PCPT and NJISP is included along with the related information gathering tools and conversations that should be used to learn about the person. These tools and conversations can help Support Coordinators build a repertoire of information gathering strategies that give life to the plans they develop.

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## PERSON-CENTERED PLANNING

Person-Centered Planning is an ongoing planning, problem-solving, and decision-making process that places the person at the center, driving development. Person-Centered Plans identify the support and health and safety needs, preferences, strengths, and desired outcomes of the person. The person-centered planning process supports individuals to be engaged in making decisions about how they envision their life now and in the future. It is used to help people choose community-based supports and services to meet their needs and assist them to achieve their outcomes.

A robust and informative person-centered planning process is required by the Centers for Medicare and Medicaid Services\* and NJ Division of Developmental Disabilities. The process must align with the description provided above and:

- provides necessary information and support to the person to ensure that s/he directs the process to the greatest extent possible
- is timely, and takes place when and where the person prefers
- offers choice with regard to the services and supports the person receives
- includes individually identified outcomes related to relationships, community participation, employment, income and savings, health and wellness, and education
- includes risk factors and supports needed to minimize them
- addresses back up plans and strategies
- includes who is responsible for implementing and monitoring the plan as well as their roles
- includes purchase/control of self-directed services as needed
- excludes unnecessary or inappropriate services and supports
- is signed by all individuals and providers responsible for implementation, with a copy provided to the individual and/or his/her guardian (as applicable)
- is distributed to the individual and others involved in the plan
- must be reviewed and revised upon reassessment of functional need, as required every 12 months, when an individual's circumstances or needs change significantly, and at the request of the individual
- reflects:
  - that the support setting was selected by the individual and is integrated in and supports full access to the greater community
  - opportunities to seek employment in competitive integrated settings
  - opportunities to engage in community life, control personal resources, and receive services in the community to the same degree of access as people without disabilities

\*Centers for Medicare and Medicaid Services (CMS), Systemwide Person-Centered Planning

## GENERAL DESCRIPTION OF THE PCPT & NJISP

The Person-Centered Planning Tool (PCPT) and New Jersey Individual Service Plan (NJISP) are planning documents required by the New Jersey Division of Developmental Disabilities. They are completed through iRecord, the Division's electronic documentation system. The PCPT and NJISP are complementary documents that should be used together to provide information about the person and the supports s/he needs to be healthy, safe, and live an active, engaged, and valued life in the community. They are developed through use of information gathering techniques and guided conversations with the person's support team.

### Additional Tips:

- Headings with bullets can be used to organize information beyond the dropdowns found in iRecord.
- Use complete ideas. Think of it as information that a reader can pick up and use. Full sentences and paragraphs may not be necessary and can detract from having clear, organized information.
- Do not copy and paste the same information into multiple sections of the plan. Excessive redundancy prevents effective use of the plan.
- Do not copy and paste from a previous Individualized Habilitation Plan (IHP). Earlier plans can be used as a source of information and resource to drive conversation, but information should not simply be moved from one plan to another.
- Those providing support should feel like they know the person after reading the PCPT and NJISP. They should be able to identify gifts, attributes, preferences, support needs, and desired outcomes for the future. Readers should also be able to use the plan to determine the support strategies that may be most effective and activities the person may want to continue, experience regularly, or be exposed to as something he or she may enjoy.

## COORDINATING THE PLANNING/TEAM MEETING

Support Coordinators are tasked with coordinating planning and team meetings. Team members should include those that play an important role in making sure the person receives the needed and preferred supports, and those that help to achieve outcomes. This may include family, friends, natural supports, and paid supporters. The person should be involved in inviting people to his/her planning meetings. The Support Coordinator can help the person determine who is important to include.

Meetings should be scheduled at the convenience of the person and the family in a place where they feel most comfortable. Support Coordinators must coordinate face-to-face meetings as required, and special consideration should be given to the location of quarterly face-to-face meeting requirements as well. Support Coordinators are not limited to only meeting on a quarterly basis and should be available to meet at other times as necessary.

When developing an initial plan or in annual plan revisions, it may be helpful for Support Coordinators to ask team members to prepare information in advance of the meeting by distributing materials with instructions. Information gathering tools offer ways to collect information to drive conversations and build the plan. An Information Gathering Toolkit by The Boggs Center on Developmental Disabilities can be found in Appendix B of this guidebook and online at the following address:

- **Exploring Possibilities & Supports: An Information Gathering Toolkit:**  
<https://rwjms.rutgers.edu/boggscenter/publications/ExploringPossibilitiesSupportsAnInformationGatheringToolkit.html>

## WORKING WITH PEOPLE THAT DON'T USE WORDS TO COMMUNICATE

Some people with disabilities do not use words to communicate or have limited speech. This does not mean that they do not communicate. All people communicate through the use of behavior and expressions. It is important that the person be included throughout the planning process regardless of his/her ability to communicate.

Support Coordinators should be attentive to a person's expressions or behavioral cues. They should also include those that know the person best and can provide information based on what the person would want. Conversation drivers that begin with words such as "describe," "explain," and "tell me about," can prompt others to share information about experiences, needs, and preferences from the perspective of the individual.

## THE THREE E'S\*

**Education, exposure, and experience** are important concepts to consider when planning and having conversations. The Support Coordinator plays a vital role in **educating** people about the service system, the underlying values and requirements related to home and community-based supports and services, and the benefits of community life for people with disabilities. Sharing real-life stories and examples of possibilities while maintaining confidentiality can be useful in helping people develop a vision for the lives they want.

Some people with disabilities have limited **exposure** to a variety of life experiences and community activities, making it challenging to determine what their preferences and/or interests are. Having conversations about ways to expose the person to activities that s/he may express interest in can increase opportunities for engagement. Having these conversations can also lead to identification of the supports and services a person may need to explore these ideas further.

People using supports may have been exposed to a variety of activities but have limited **experience**. This is especially true in instances where those that provide support do more for the person than with the person. The more a person is involved in contributing to his/her household and community, the more opportunities for learning, growth, increased inter-dependence and meaningful inclusion. Support Coordinators should have conversations about the experiences a person may be interested in, include this information in the plan, and help the individual to identify the supports and services needed to realize this.

### THE FIVE FACTORS\*

All plans should include information to help supporters address quality indicators within the following five factors: My Human Security, My Community, My Relationships, My Choices, and My Goals. Details are listed in Appendix D on page 58.

### THE NEW JERSEY COMPREHENSIVE ASSESSMENT TOOL (NJ CAT)

#### Description & Purpose

The New Jersey Comprehensive Assessment Tool (NJ CAT) is the mandatory needs-based assessment used by the Division of Developmental Disabilities as part of the process of determining an individual's eligibility to receive Division-funded services.

The NJ CAT assesses an individual's support needs in three main areas: self-care, behavior, and medical. Once deemed eligible to receive Division services, the NJ CAT is used to determine the person's individual budget.

#### Use in Planning

Where support needs are identified in the NJ CAT, the Support Coordinator should have conversations about the details of the support need, including support strategies and preferences that are specific to the person.

Information from the NJ CAT should **not** be copied and pasted into the plan. Only information relevant, age-appropriate, and current to the person's needs should be addressed in the plan. Support Coordinators should have conversations driven by needs identified in the NJ CAT to determine how the person needs to be supported in these areas. Including the 'how' in the plan is useful to those providing supports and can be invaluable in situations when the supporters change and new staff need to be trained on strategies to best support the person.

Often, people that support the individual, clinicians, or other professionals have developed instructional documents, protocols, and/or procedures. These documents should be identified in the plan and uploaded to iRecord. These may include behavior support plans, medical protocol, mobility/transfer instructions, etc.

\*The Council on Quality and Leadership

**Acuity**

Identified acuity must be documented and communicated to service providers. The Addressing Enhanced Needs Form is required for those individuals with an assessed acuity and must be completed by both the Support Coordinator and the provider(s) and uploaded into iRecord.

**INFORMATION GATHERING TOOLS & CONVERSATIONS**

The PCPT and NJISP should not be developed simply by reading the iRecord tile heading and filling in the fields. A variety of tools and conversations should be used to learn about the person, with relevant information included in the most appropriate tiles. Information gathering tools should be used to drive conversations to learn about the person and capture information to identify needs, preferences, outcomes, and services necessary to provide effective supports.

Information gathering tools are conversation drivers. The information gathering tools included in this guidebook are used across the country to develop robust and descriptive person-centered plans. Not everything learned through using these tools will be relevant to the planning process. It is up to the Support Coordinator, working in partnership with the person and those that care about him/her, to extract relevant information and document what is needed by others to truly know the person, assure health and safety, provide effective supports, increase experiences and opportunities, help the person be a valued, contributing member of his/her community, and achieve outcomes.

The conversation prompts and follow-up questions presented in this guidebook are suggestions. These are meant to provide a starting point for discussions, and are not exhaustive. Effective Support Coordinators know the best person to respond to each question, how to rephrase as needed, and when to use additional conversation prompts based on the current discussion, their relationship with the person, experience, and gaps in information.

Each of the suggested conversation prompts provided in this guidebook are phrased as if talking to the person supported. They may need to be rephrased to help with understanding. Support Coordinators may also need to use interpreters (both formal and informal) to help the person understand what is being asked. These questions may be revised to trigger conversations with those that support and/or care about the person as well. Support Coordinators are encouraged to develop their toolkit of conversations that build rapport and help to learn more about the person's needs, preferences, and vision for life.

Support Coordinators may generate ideas and hypotheses as they facilitate conversations to develop the plan, but should never document information that is based on assumptions. If a Support Coordinator has an idea or hypothesis, it should be verified with the person or those that care about the person before putting into the plan.

## CROSS-WALKING

Effective person-centered planning does not take place in a routine, section by section manner. Through conversations, Support Coordinators will learn information that can be used to build multiple sections of the plan. This is called cross-walking. Cross-walking involves asking follow-up questions in a natural conversation to gain information that pertains to other sections of the plan. The same information should never be copied and pasted into multiple sections of the plan; this is not cross-walking.

Examples of cross-walking are provided in this guide. They are intended to show how having conversations about information included in one section of the plan can lead to important information for other sections of the plan. These are examples, as conversations will lead to different responses depending on each person.



See diagrams presented in Appendix A for visual examples of how information gathering tools, conversations, and cross-walking are used to develop the plan.

## iRECORD

The iRecord planning platform contains dropdowns in each section. These dropdowns should be used to help further organize the information based on category. When entering information, Support Coordinators should use the category that best matches the information presented and avoid copying and pasting the same information into multiple sections. Sometimes the information may not apply to the dropdowns provided. In these instances the “other” category should be used.

iRecord does not have spelling or grammar check features. Support Coordinators should review the information they enter and make revisions as necessary.



## PCPT & NJISP DEVELOPMENT – SECTION BY SECTION

### PERSONAL

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**Description:** This section of the plan provides basic identifying information about the person.

**Purpose:** This section provides contact information as it relates to the person, including birthdate, residence, etc.

**Development Strategies:** Support Coordinators should complete this section and review periodically to make sure everything is up to date. Information found in this section is used to contact the individual, guardians, and/or others that may be the primary point of contact for the person.

### CONTACT

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**Description:** This section of the plan provides information about the individual's primary point of contact.

**Purpose:** This section is used to capture the information necessary to contact those involved in planning and approvals. It also is used to identify if the person listed is the emergency contact, and the access s/he has to information per HIPAA or legal guardianship. The person may also be identified as a contributor to the assessment. If the individual is inactive in the person's life, this may also be noted here.

### RELATIONSHIPS

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**Description:** This section of the plan lists the people in the person's life, including family, friends, paid and natural supports, and others that play a role in the person's life.

**Purpose:** This section documents who is in the person's life and can be useful in cultivating a strong circle of support, identifying who may be called upon to provide support, and recognizing the types of people that best support the person. This section can also be used by Support Coordinators to identify people the individual may want to include as part of the planning team or those that could provide information to inform the plan.

## Development Strategies:

### Information Gathering Tools

The Relationship Map is helpful in learning about the family, friends, and supporters that are in the person's life and helps to distinguish the importance and closeness of the relationship. Use this tool to drive conversation.

### Conversations

- With whom do you like to spend time?
- Who is in your family? Who are your friends?
- Who do you want to share your achievements with?
- What specific things are important to know about this person (e.g. they shouldn't be given personal information, relationship concerns, doesn't want a relationship with)?
- Who is important in your life?
- Who do you talk to when you're happy? Sad? Lonely?
- Who helps you the most?
- Who shouldn't be involved in the planning process or be provided with information?

### iRecord Dropdowns

Multiple categories describe the person's relationships. Information to further describe these relationships and important things about each relation can be included in the notes section. Include contact information and any key points about the relationship here.

### Cross-walking to Other Sections

The following are some conversations about *Relationships* that can inform other sections.

#### *Important To You:*

- What do you enjoy doing with [insert name of those the person enjoys being around/ is significant in his/her life]?
- What do you like best about [insert name]? *Does the answer provide information about what is Important To how s/he wants to be treated, valued, or respected?*

#### *Supporter Qualities:*

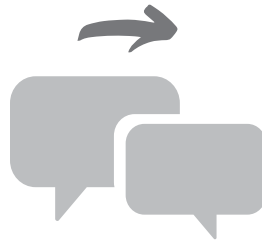
- What do you like about [insert name]?
- Which of these characteristics would you like to have in someone that supports you?

Cross-walking Example: Relationships

**Relationships**

Penelope Phillips - Aunt

**Conversations**



**Important to You**

*Things to Do*

- Visiting Aunt Penelope in Florida every year
- Going to the beach
- Playing miniature golf
- Taking the boat out

**Supporter Qualities**

*Characteristics of Supporters*

- Patient and soft-spoken
- Enjoys being outdoors and being on the go

## STRENGTHS & QUALITIES

**Description:** This section describes what is liked and admired about the person from his/her perspective as well as the point of view of those who care about him/her.

**Purpose:** Knowing the gifts, qualities, and capacities within the person is helpful in many ways. It is important that people are supported in ways that help them to share and promote their strengths. This information also helps supporters identify the types of activities the person may want to be exposed to in order to fully realize his/her strengths and capacities and become a valued member of his/her community.

**Development Strategies:**

Information Gathering Tools

- Great Things About Me

Conversations

- What do you like about yourself?
- What is great about you?
- What are some things you do well?
- What do others like about you?
- What are some of your greatest achievements?
- What are some of your positive qualities?

iRecord Dropdowns

- Like about self
- Others like about you
- Achievements
- Things you do well

### Cross-walking to Other Sections

Sometimes a person’s gifts and capacities translate into something that is *Important To* the person and/or a *Support Need*. Only information that enhances or expands knowledge of the person, and is not copied and pasted, should be cross-walked.

#### *Important To You:*

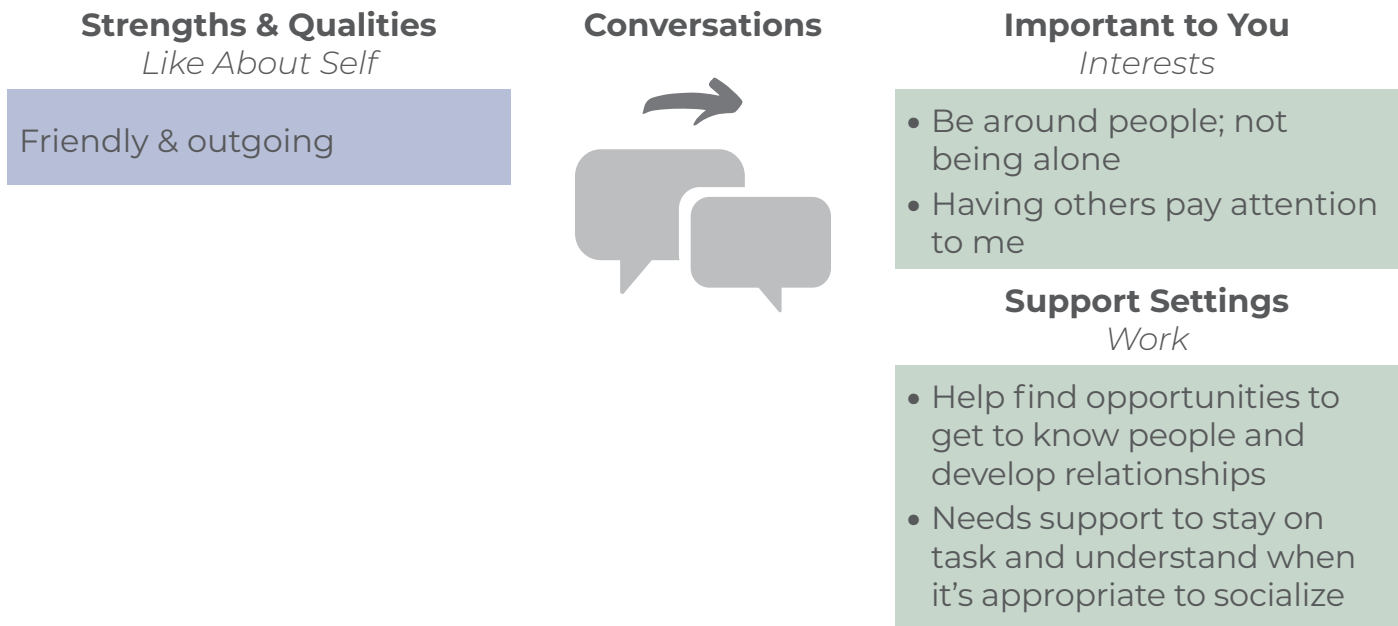
- Is there something about [quality/skill] that is important to you?
- Does [quality/skill] mean that it’s important to you to [insert idea]?

#### *Support Settings:*

Use conversations and body language to determine if there are support needs related to *Strengths & Qualities*. Sometimes strengths are an asset in certain places and an issue that may require a support need in others.

- Are supports needed for [insert name] to continue to share his strengths?
- Are supports needed so this achievement can continue?

### Cross-walking Example: Strengths & Qualities



## IMPORTANT TO YOU

**Description:** This section provides information about what the person says/shows is important to him/her. It is meant to capture information from the person’s perspective. The information may be based on what the person says and/or through observations of actions and behaviors.

**Purpose:** Knowing what is important to a person is instrumental in developing effective support strategies. Supports are most effective when they take into account the needs of the person and their preferences as illustrated in this section. This

section is also helpful in identifying what may need to be maintained or enhanced in a person's life. Often *outcomes* may be derived from a need for the person to obtain more of what is important to him/her.

### Development Strategies:

#### Information Gathering Tools

The following tools are helpful to drive conversations that identify what is important to the person:

- Relationship Map
- Routines [Morning, Evening, Transition, Getting Home, Comfort, Celebration, Religious/Cultural, etc.]
- Good Day / Bad Day [Weekday and Weekend]
- Looking Back/Looking Forward
- LifeCourse Trajectory Worksheet

#### Conversations

- What are some things you enjoy doing at work, home, community, free time...?
- What are some things you don't like to do? (*How does this relate to what is important to the person?*)
- How do you want people to treat you? (*Consider privacy, making decisions, sharing concerns, etc.*)
- What would you like to change in your life? Why?
- What would you like to learn or accomplish?
- How do you like others to show that they respect/value you?
- What makes you feel safe at home, work, in your community...?
- What do you want to keep the same in your life? Why?
- What are some things you want to do, but are told that you can't?
- What are your gender identity preferences?
- Environmental Scan – Use the person's environment to generate conversations about what may be important to him/her.

*See conversations cross-walked from Relationships.*

#### iRecord Dropdowns

- Personal Preferences/Routines
- Places to Go
- Interests
- Things to Do
- People to See/Relationships
- Recreational Pursuits
- Dislikes
- Pets
- Others

#### Cross-walking to Other Sections

##### Support Settings:

- What supports do you need to make sure you have [something that is important to the person]?

As conversations take place to learn what is *Important To* the person, information about the supports they need to obtain will likely also be shared. When support needs are identified, they should be included in the *Support Settings* section using the category that best fits the situation – Community, Home, Work, or None.

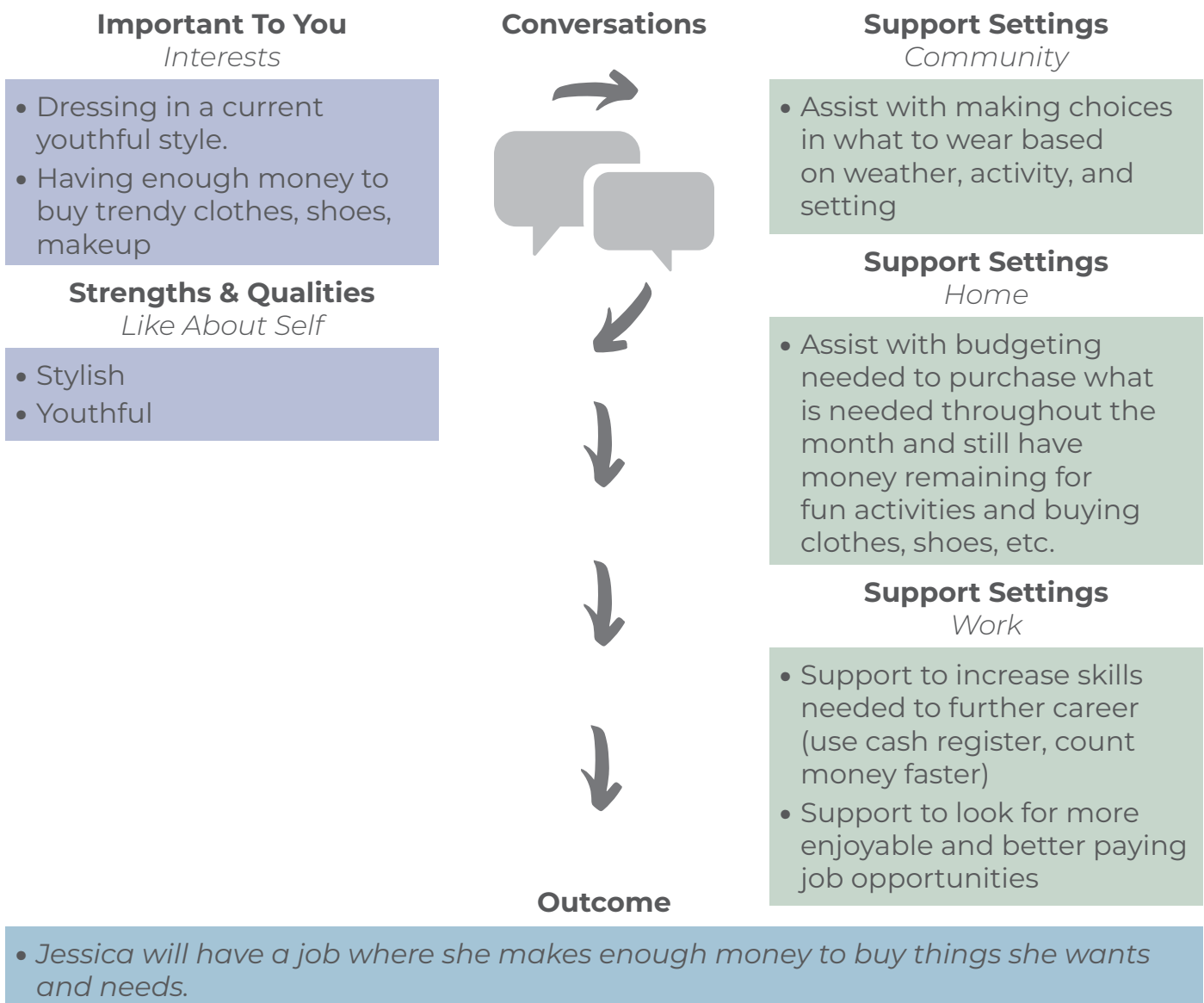
**Strengths & Qualities and Hopes & Dreams:**

Throughout these conversations, new information about the person's *Hopes & Dreams* and *Strengths & Qualities* may also be learned, and should be included in those sections.

**Outcomes:**

*Outcomes* will frequently relate to what's *Important To* the person. An *outcome* may be warranted in situations where a person expresses that something is *Important To* him/her, but they aren't achieving it. This is usually the case when it is something that involves long term support and/or services to address. In other cases, an *outcome* may not be needed. Instead, it may only require that a support be put in place by a service provider or natural/generic support. The extent of the need should drive whether or not an *outcome* is warranted.

Cross-walking Example: Important to You



## HOPES & DREAMS

**Description:** The section captures information about the person's short- and long-term hopes and dreams.

**Purpose:** Identifying the person's hopes and dreams provides insight into who they are and where they see their life in the future. This information is helpful to learn more about what is important to the person and can also be used to develop outcomes that focus on the person's vision for the future.

### Development Strategies:

#### Information Gathering Tools

- Life Trajectory Worksheet
- Looking Forward

#### Conversations

- What are your hopes and dreams for yourself?
- Is there something you'd like to be doing that you don't do now?
- Is there anywhere you'd like to go/travel to?
- What is your dream job?
- If you had all the money and power in the world, what would you do?
- How do you want your life to be different?
- What new things would you like to learn?
- Where do you dream of living?
- What kind of relationships do you want to have in your life?
- What are some things that your siblings do that you'd like to do too? Why?

#### iRecord Dropdowns

- Short-term Hopes & Dreams
- Long-term Hopes & Dreams

#### Cross-walking to Other Sections

##### **Important to You:**

As the person shares his/her *Hopes & Dreams* of the future, some things that are *Important To* the person may become apparent and should be documented upon verification.

##### **Outcomes:**

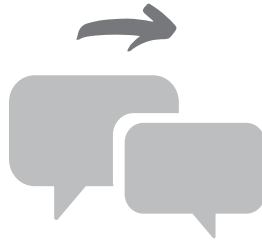
*Hopes & Dreams* frequently have a direct connection to personally-defined *outcomes*. Exploration should take place to determine if the person would like to use the supports and services available to him/her to pursue these hopes and dreams. Supports that are necessary for the person to achieve these hopes and dreams should also be documented in the *Support Settings* sections.

Cross-walking Example: Hopes & Dreams

**Hopes & Dreams**  
*Long-term*

- Live close to mom in own apartment with a cat

**Conversations**



**Outcome**

- Julie will participate in volunteer and other activities where she can learn to care for animals.
- Julie will live in her own apartment, close to her mom's neighborhood, with a cat.

**Important To You**  
*Recreational Pursuits*

- Being around and taking care of animals
- Feeling loved

**Support Settings\***  
*Home*

- Support needed to shower. See attached protocol for preferences with bathing. Prefers a shower, but must have a shower chair and support to sit up. Wants to clean self as independently as possible.
- Support to make basic and advanced meals. Help is needed with cutting, using stove, and using the microwave. Can cut own food at mealtime, but sometimes needs assistance with getting pieces small enough. Prefers softer food that is in small pieces.
  - Other household support needs...

\*Note: This example does not suggest that the person be able to do these things independently in order to achieve his/her outcome to live on her own, rather that these supports will need to be in place.



## COMMUNITY INTEGRATION

**Description:** This section describes the things that the person does in the community.

**Purpose:** People with disabilities have the same access to the community as people without disabilities. Service providers and other supporters play an important role in making sure that people are able to participate in community activities as much as they would like. Information found in this section can be useful in identifying things the person likes to do in the community, and it can also be used to identify gaps and potential opportunities to expose the person to new experiences s/he may enjoy and find meaningful.

### Development Strategies:

#### Information Gathering Tools

The following tools are helpful to drive conversations that identify where the person spends time in his/her community. It is likely these tools would have been used to capture information for other sections so that some information would be cross-walked already.

- Good Day / Bad Day [Weekday and Weekend]
- Routines [Celebration, Religious/Cultural, etc.]

#### Conversations

- Do you talk to, see, and/or visit with neighbors? Where? When?
- Do you volunteer? Where?
- Is there somewhere you'd like to go that you don't get to very much or at all?
- How often do you get out to see friends? Where do you go?
- How often do you run errands in the community? (e.g. bank, shopping, etc.)
- How do you like being around people? Crowds?
- Do you work? Where?
- Where do you go for fun?
- How do you choose what you do? Are there things you'd like to do, but don't get a chance to?
- Describe your friendships. Would you like the opportunity to meet more people?
- Are there new activities you'd like to try?
- Are there things you did/places you went in the past that you enjoyed?

#### iRecord Dropdowns

- Previous/Current Experiences
- Extent of Interaction with the Community

#### Cross-walking to Other Sections

This section will often be built through conversations focused on building other sections of the plan. For instance, community experiences will likely be shared in the development of the *Important To* section.

***Support Settings:***

When learning about the places in the community the person visits, it is helpful to learn what supports are necessary for the individual to participate and/or contribute.

***Outcomes:***

Additionally, if the person expresses interest in doing more in the community and/or needs support to maintain the amount of activity s/he currently has, an *outcome* may be needed.

Cross-walking Example: Community Integration

**Community Integration**

*Previous/Current Experiences*

- Restaurants (Local Diner, Applebee's, TGI Fridays) – prefers going early or when it's not crowded
- Used to go to concerts in Camden
- Visiting PetSmart
- Ice Cream Shop on Saturdays, when there are local bands

**Community Integration**

*Extent of Interaction with the Community*

- Would like to try new things and get out more
- Likes the chance to choose what to do and not always go as a group (it's too hard to find a table quickly and takes too long to find a place everyone agrees on)

**Conversations**



**Support Settings**

*Community*

- Assistance is needed to stay calm when she may need to wait. Prepare in advance, let her know when she may need to wait and approximate time, bring things to do (word finds, iPad, etc.), and remind her of deep breathing strategies.
- Support to save money to make larger purchases (concert tickets)
- Support to find free or low-cost activities
- Transportation is needed to get places
- She is shy and prefers having someone to introduce her to make connections. Prompt her to engage then fade out.
- May become destructive when she doesn't get immediate attention or what she wants. She will grab things and toss them on the floor. If this happens, gently guide her away from the situation and things she can throw, remind her to take deep breaths, and tell her a calming story to distract her. Talking about animals works best.

**Important To You**

*Interests*

- Music (Pop, 70's & 80's, R&B – Loves Lady Gaga)
- Animals – especially small ones like turtles and hamsters
- Eating junk food – loves burgers, French fries (no sauce, ketchup)

**Outcome**

- *Trina will participate in community activities that match her interests and expose her to new opportunities.*

## SUPPORTER QUALITIES

**Description:** This section includes personality characteristics that the person would like to see present in those that support him/her.

**Purpose:** The ability to match people with staff based on personality characteristics and interests is valuable for many reasons. A good staff fit increases the likelihood that s/he will be engaged in implementing the plan and supporting the person to get the life s/he wants and often facilitates longevity when the staff and person supported develop a genuine bond.

Some of the information found in this section can be used to develop advertisements for staff and when writing interview questions. (Please note, employers must always follow laws and requirements pertaining to equal employment opportunity and fair employment practices.)

### Development Strategies:

#### Information Gathering Tools

The following tools, as already used to complete other sections, may also lead to conversations that identify supporter qualities:

- Relationship Map
- Good Day / Bad Day
- Rituals & Routines

#### Conversations

- What traits are you most compatible with?
- Describe the ideal supporter for you.
- What characteristics do you like in others?
- Are there any special skills/experience/training you would want staff to have?
- What kind of people do you like to be around?
- What are some common interests you'd like to be able to share?
- What are some characteristics that bother you?
- What are some qualities you want your staff to have?

#### iRecord Dropdowns

- Characteristics of Supporters
- Other

#### Cross-walking to Other Sections

Often, information will be cross-walked into this section through use of information gathering and development of prior sections.

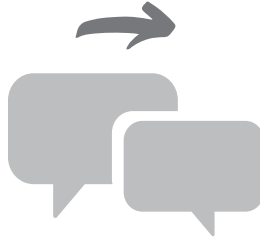
**Support Settings:**

Sometimes when having conversations related to this section, information about the way the person wants to be supported is discussed. This information should be included in the *Support Settings* section.

## Cross-walking Example: Supporter Qualities

**Supporter Qualities***Characteristics of Supporters*

- Patient
- Prompt and time conscious
- Creative
- Energetic
- Firm, but polite in approach
- Quiet, calm demeanor

**Conversations****Support Settings***Community*

- Dislikes noisy environments and may get agitated. Support him by providing reassurance and calmly guiding him to a less noisy area.
- Identify a quiet place at locations to go to as needed. If able, do this in advance of going or call ahead to learn about the environment.
- Keep him apprised of what is happening and when. If a plan is being changed, let him know in advance and provide alternatives that he enjoys.

## COMMUNICATION STYLES

---

**Description:** This section captures how the person communicates. It includes information about non-verbal communication, including how the person lets others know if s/he is happy, sad, excited, angry, or not feeling well. It may also be used to capture how the person lets one know if s/he disagrees, agrees, understands, wants to go somewhere, etc.

**Purpose:** Everyone communicates through a variety of methods. It is important to understand the way a person communicates using body language, facial expressions, and behavior. Documenting how people that rarely or never use words communicate helps to reduce frustration, increases well-being, and helps the person to be included in decision-making and activities within their home and community.

## Development Strategies:

### Information Gathering Tools

- Good Day/Bad Day – When using this tool, inquire about how a certain activity contributes to good or bad days for the person. Also ask questions like, “How does the person show you that s/he doesn’t like this?” Having this information will feed this portion of the plan and also provide greater insight into how the person uses behavior or expressions to communicate.
- How the Person Communicates Chart

### Conversations

- How do you prefer to communicate?
- How do you let someone know that something is wrong?
- Do you use any communication devices or other technology to communicate?
- What is your preferred language?
- How do you let someone know you are not feeling well or you’re in pain?
- How do you let someone know that you’re happy, sad, scared, excited, or any other feeling?
- Do you read or write? To what extent?
- How do you let someone know you want to do something/don’t want to do something?
- How do you prefer others to communicate with you?

### iRecord Dropdowns

- Read/Write
- Express emotion
- Express illness, pain, discomfort
- Express wants/needs/choices
- Express understanding
- Express lack of interest/desire
- Other

### Cross-walking to Other Sections

#### *Support Settings:*

Conversations used to complete this section may also identify specific support needs. Specifics should be documented accordingly.

Cross-walking Example: Communication Styles

**Communication Styles**

Jill will pull her hair out, hit herself with force, and damage property when she is anxious, agitated, or overstimulated.

**Conversations**



**Support Settings**

*Home*

- Jill has a body pillow she uses for comfort. When she becomes agitated, someone should sit on the couch with her and her pillow. The pillow can be placed in such a way to help her avoid hitting herself.
- Jill needs 1:1 supervision that stays within 5 feet of her at all times.
- Jill wears a helmet, faceguard, and mittens when she becomes self-injurious and other attempts to calm her are ineffective.
- When a staff person learns about what may be making Jill agitated or anxious, this should be communicated with others and the team will work to determine proactive ways to provide support.

**Support Settings**

*Community*

- Jill wears a helmet when she leaves the house due to her self-injurious behavior.

**Community Integration**

- Jill does not participate in community activities on a regular basis due to concerns related to self-injurious behavior.

**Outcome**

• Jill will increase opportunities to participate in the outdoor recreational activities she enjoys.

## EMPLOYMENT

### PATHWAY TO EMPLOYMENT ASSESSMENT

**Description:** This section is used to document the person's current employment status.

#### Having Conversations About Employment:

New Jersey is an 'Employment First' state. This means that competitive, integrated employment is the first and preferred activity for all working-age citizens, regardless of disability. 'Employment First' is about creating an environment for people with disabilities that empowers them with choices for their future, reduces poverty, and provides a sense of achievement and opportunities to make valued contributions to their communities. Underscoring employment as one of the fundamental functions in a person's life, every NJISP must contain at least one outcome related to employment.

Historically, individuals with disabilities have had limited access to opportunities when pursuing employment outcomes for themselves. Because employment has not always been an expectation, some people with disabilities or their families may not believe employment will work for them. Support Coordinators will need to navigate difficult conversations tactfully to address concerns about employment, including: perceptions of risks to safety, fear of losing benefits, cultural considerations, significant medical needs or challenging behavior, and any other barriers. This involves a combination of listening, observing, validating concerns, and educating.

While some people may already be employed, or are very open to finding immediate employment, others may prefer to take smaller steps on the path to achieving employment.

As with any outcome included in the ISP, employment outcomes may take years to achieve and involve lifelong skill development.

#### Development Strategies:

##### Information Gathering Tools

Use the Pathway to Employment tool available in paper form or in iRecord to provide information about the status of the person's employment.

In the Pathway to Employment Dropdown, select the individual's current employment status (options listed below). Ask the questions related to the status selected and mark according to the responses provided. Include additional information gained through the conversation in the notes sections.



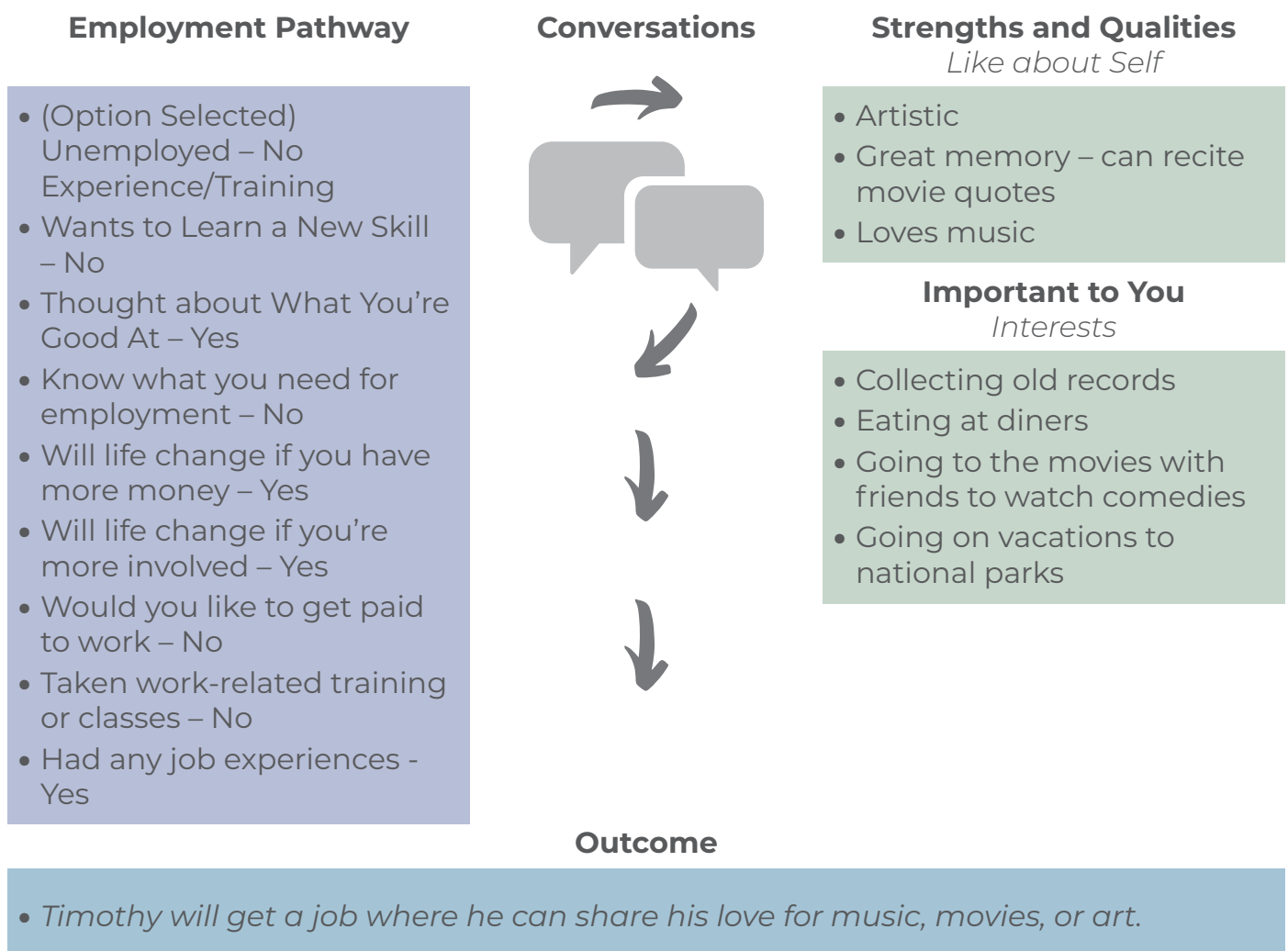
iRecord Dropdowns

- Employed
- Unemployed- Experience/Training
- Unemployed- No experience/ Training
- Unemployed- Not Pursuing

Cross-walking to Other Sections

Use the information learned through completing the Pathway to Employment tool and additional conversations to identify an employment-related outcome as required by NJ DDD.

Cross-walking Example: Employment Pathway



## EMPLOYMENT HISTORY

**Description:** This section is used to document the person’s history of employment, including past work experiences.

### Development Strategies:

#### Conversations

Ask the person and those that support him/her to describe jobs s/he has held. Document accordingly.

#### iRecord Dropdowns/Open-ended Fields

- Company Organization Name
- Industry Type (see table below)

Agriculture & Forestry/ Wildfire	Business Services	Computer and Electronics
Construction/Utilities/ Contracting	Consumer/Personal Services	Education
Energy, Natural Resources, Environmental	Finance & Insurance	Food & Hospitality
Government	Health Services	Manufacturing
Media and Entertainment	Non- Profit	Retail
Safety/Security & Legal	Software and Internet	Telecommunications
Transportation & Storage	Travel, Recreation, and Leisure	

- Industry Subtype
- Role/Title
- Start Date/End Date (Check if present)
- Wage & Benefit Information
- Address
- Notes – *Include any notes that would be helpful for those supporting the person to gain, maintain, expand, or change employment.*

## NEW CAREER AND UNPAID EXPERIENCES

**Description:** This section is used to document the person’s history of unpaid work experiences and career planning opportunities.

### Development Strategies:

#### Information Gathering Tools

- Pathway to Employment

#### Conversations

Ask the person and those that support him/her to describe any unpaid work experiences s/he has had. Inquire about any career planning activities that have taken place.

#### iRecord Dropdowns/Open-ended Fields

- Company/Organization Name
- Industry Type (see table below)

Agriculture & Forestry/ Wildfire	Business Services	Computer and Electronics
Construction/Utilities/ Contracting	Consumer/Personal Services	Education
Energy, Natural Resources, Environmental	Finance & Insurance	Food & Hospitality
Government	Health Services	Manufacturing
Media and Entertainment	Non- Profit	Retail
Safety/Security & Legal	Software and Internet	Telecommunications
Transportation & Storage	Travel, Recreation, and Leisure	

- Industry Subtype
- Experience Type
  - Internship
  - Job Sampling
  - Situational Assessment

- Training
- Volunteer
- Start Date/End Date (Check if present)
- Description of Duties/Tasks/Experience
- Average Hours per Timeframe
- Address
- Notes: *Include any notes that would be helpful for those supporting the person to gain, maintain, expand, or change employment.*

**NEW CAREER RELATED EDUCATION**

**Description:** This section is used to document the person’s history of career-related education.

**Development Strategies:**

*Conversations*

Ask the person and those that support him/her to describe any educational experiences that were designed to help secure employment.

*iRecord Dropdowns/Open-Ended Fields*

- School, Organization, or Sponsor Name
- Industry Type (see table below)

Agriculture & Forestry/ Wildfire	Business Services	Computer and Electronics
Construction/Utilities/ Contracting	Consumer/Personal Services	Education
Energy, Natural Resources, Environmental	Finance & Insurance	Food & Hospitality
Government	Health Services	Manufacturing
Media and Entertainment	Non- Profit	Retail
Safety/Security & Legal	Software and Internet	Telecommunications
Transportation & Storage	Travel, Recreation, and Leisure	

- Industry Subtype
- Education Type:
  - College- level class
  - Specialty class
  - Day camp
- Start Date – End Date (Check if present)
- Is this an official education program (mark yes or no)
- Short description of Education
- Additional Notes

## VOTING

**Description:** This section identifies the person’s voting registration status and interest in participating in the voting process.

**Purpose:** The ability to vote is a civil right that people with disabilities should be supported to realize should they choose.

### Development Strategies:

#### iRecord Dropdowns

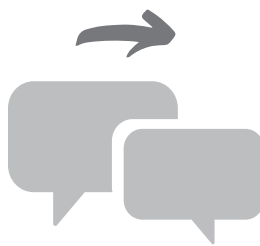
- Registered to vote
- Do you want to register?
- Are you planning to vote?
- Do you need support to vote?

#### Cross-walking Example: Voting

##### Voting

- Registered to vote – Yes
- Are you planning to vote – Yes
- Do you need support to vote - Yes

##### Conversations



##### Important to You

- Participation in community events
- Sharing my opinion

##### Support Settings

*Home*

Sam is interested in voting and needs someone to help him learn about the candidates.

##### Support Settings

*Community*

Sam would like to vote and needs to have someone drive him there, provide support while waiting in line, and read the options to him in the voting booth.

## SAFETY & SUPPORT NEEDS

### SUPPORT SETTINGS

**Description:** This section describes what others need to know and do to support the person at home, work, or in the community.

**Purpose:** The information found here should be used by supporters to better understand how the person wants to be assisted to complete a variety of tasks, maintain health, safety, and well-being, and have what is important to him/her.

### Development Strategies:

#### Information Gathering Tools

The following tools, as already used to complete other sections, may also lead to conversations that identify support needs:

- Relationship Map
- Good Day / Bad Day
- Rituals & Routines
- NJ CAT

#### Conversations

The NJ CAT should be used to drive conversations to build this section. Information should not simply be transposed from the assessment. Instead, conversations should take place to determine techniques, strategies, and preferences around the support that may need to be provided.

As a person identifies a support need, ask:

- Do you need support to...
- What should that support look like?
- How do you *not* want to be supported? Are there things you don't like?

In addition to having conversations related to the NJ CAT you should have conversations related to:

- The supports the person needs to have what is *Important To* him/her
- The supports the person needs to be actively engaged and included in his/her community
- Supervision needs:
  - In a vehicle
  - At home, in the community, at work, etc.
- Line of sight, alone time, etc.

- Supports needed to effectively evacuate an emergency situation (e.g. fire, natural disaster, etc.) What is the evacuation plan and where can it be found?
- Medication and the supports the person may or may not need to take medication.
- Finances and the supports a person may need to manage his/her money, go shopping, etc.

Existing service providers may have/provide information related to support needs of the individual. They may need to have some information included in the plan due to regulatory requirements. Conversations should take place with the person, provider, and those that care about the person to make sure needed supports are identified in the plan and put in place. This information should be reviewed regularly to identify an increase or decrease in support need, a change in the preferred method of support, and/or a change in the way supports/services are provided. The information provided may be included in the *Support Settings* sections or another more applicable support related section of the NJISP.

#### iRecord Dropdowns

- Community
- Home
- Work

#### Cross-walking to Other Sections

Often, information will be crossed-walked into this section through use of information gathering and development of prior sections.

#### *Important To You:*

Sometimes when having conversations related to this section, information about what is important to the person may come up. This information should be included in the *Important To* section.

#### *Supporter Qualities:*

It is helpful to ask about characteristics the person would like to have in supporters when learning about support needs. This information should be included in the *Supporter Qualities* section.

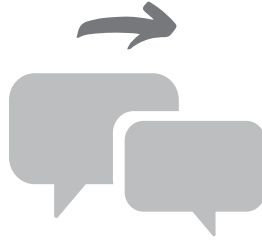
Cross-walking Example: Support Settings

**Support Settings**

*Community*

Needs to have Depends changed every few hours. Plan ahead when going out for long periods of time, know where family restrooms are in the area. Make precautionary stops when needed.

**Conversations**



**Important To You**

*Personal Preferences / Routines*

Not being embarrassed. Appreciates privacy and being treated with respect, especially around hygiene and using the restroom.

**Supporter Qualities**

*Characteristics of Supporters*

- Knowledge of local community and/or ability to learn about new places to go and activities to participate in
- Respectful and discreet

**RELIGIOUS/ CULTURAL INFORMATION**

**Description:** This section captures specific information about the religious and cultural preferences of the person.

**Development Strategies:**

Information Gathering Tools

- Rituals & Routines – Religious/Cultural

Conversations

- Do you go to a house of worship? Is there a preferred location?
- What activities do you participate in at your place of worship?
- Tell me about any religious or cultural traditions that you used to participate in and would like to again?
- What religious practices would you like to participate in? Describe...
- What cultural practices would you like to maintain, practice? Describe...

iRecord Dropdowns

- Religious
- Cultural
- Spiritual
- Other
- None



## BEHAVIOR/SENSORY NEEDS

**Description:** This section is used to describe behavior support needs and/or sensory supports needed by the person.

### Development Strategies:

#### Information Gathering Tools

- DDD Mental Health Pre-Screen Checklist
- NJ CAT

#### Conversations

- Use the DDD Mental Health Pre-Screen Checklist to drive conversations. For questions that are answered 'yes,' determine if this is preventing the person from achieving something s/he wants in life and/or if support is needed.
  - This tool should be used to review the need for mental health treatment. If a need is determined, a copy of the document should be given to the person, family, and/or provider to identify treatment resources and give to the MH Provider, physician, nurse practitioner, or similar professional.
  - If a need was determined, the Support Coordinator must follow-up to determine if treatment has been secured, identify any plan revision needs, and/or determine if any next steps are necessary.
- Use the NJ CAT to drive conversations related to behavior/sensory needs. Include information about ways to support in this section.
- Ask those that care about and support the person to describe any behavior or sensory support needs the person may have. Ask them to describe the best ways to provide support.
- Ask if there are any behavior supports plans currently in place. Inquire about the effectiveness of the plans and if anything needs to be changed. Upload behavior plans to the iRecord as an attached document and reference it in the plan.

#### iRecord Dropdowns

- |                 |                  |
|-----------------|------------------|
| • Aggression    | • Interactions   |
| • Behaviors     | • Sensory Issues |
| • Elopement     | • Other          |
| • Fears/Phobias |                  |

## COMMUNICATION

### Check those that apply:

- Non-Verbal
- ASL
- Limited Verbal
- Primary Language [Enter Text]

## MOBILITY/ADAPTIVE EQUIPMENT

**Description:** This section includes information about the person's mobility needs and use of adaptive equipment.

### Development Strategies:

#### Conversations

Use the NJ CAT to drive conversations about the person's mobility and adaptive equipment needs. Ask for specifics about when and where the equipment may be used (e.g. the person may use a cane in some instances and a wheelchair in others). Ask about supports that may be needed to use equipment and/or ensure maintenance and function.

#### iRecord Dropdowns

- Crutches
- Walker
- Wheelchair
- Other (e.g. glasses, hearing aids, assistive technology devices, bed rails, grab bar, hoist lifts, etc.)
- None

## HEALTH & NUTRITION

### ALLERGIES

**Description:** This section includes information about any allergies the person may have.

### Development Strategies:

#### Conversations

Ask the person and those that know him/her best if they have any environmental, food, or medicine allergies. Determine if there are specific support needs related to this (e.g. ensure person has EpiPen). Document accordingly.

- How do you know the person is having an allergic reaction?
- What needs to be done when the person has a reaction?
- What's the protocol?

## iRecord Dropdowns

- Environmental
- Food
- Medicine
- Other

**HEALTH HAZARDS/CONCERNS**

**Description:** This section is used to document health hazards or concerns that are necessary for supporters to be aware of to ensure the person's health and well-being.

**Development Strategies:***Conversations*

Use the NJ CAT to drive conversations about the person's health and safety needs. Ask about specific supports that may be needed to ensure health and safety.

Use the iRecord Dropdowns to discuss if support is needed in any of the areas listed. This information should be included in the notes section and additional information can be cross-walked into the *Support Settings* section as needed.

- How do you know the person is having seizure? What needs to be done when the person is having a seizure? What's the established plan to provide support?
- As applicable, ask the team to describe the supports that may be needed due to risk for any of the concerns identified in the dropdown (e.g. aspiration, bowel impaction, choking, etc.)

## iRecord Dropdowns

- Aspiration
- Bowel Impaction
- Choking
- Constipation
- Dehydration
- Falling
- Seizures
- Swallowing Disorder
- Other

**SMOKING HISTORY**

**Description:** This section is used to document the person's history with smoking.

**Development Strategies:***Conversations*

- Ask the person and those that care about him or her to describe his/her smoking history.
- If the person quit smoking and/or currently smokes but wants to quit, inquire about supports needed to do this.

## DIETARY

**Description:** This section captures information about the person's dietary needs, including food preparation instructions necessary to maintain health and safety.

### Development Strategies:

#### Conversations

- Use the NJ CAT to drive conversations about the person's health and safety needs. Ask about specific supports that may be needed to ensure health and safety.
- Use the iRecord Dropdowns to discuss if support is needed in any of the areas listed.
- If there are prescriptions or specific dietary requirements/preferences, this information should be included in the comments section within the dropdown topic.

#### iRecord Dropdowns

- Food Prep (Diet)
- Food Prep (Liquids)
- Special Diet
- Tube Fed

## SELF-CARE

**Description:** This section is used to document support needs as they relate to common areas of self-care and hygiene.

### Development Strategies:

#### Conversations

- Use the NJ CAT to drive conversations about the person's health and safety needs. Ask about specific supports that may be needed to ensure health and safety. Do not just copy and paste from NJ CAT.
- Use the iRecord Dropdowns to discuss if support is needed in any of the areas listed.
- Add prompts about what it looks like, description of assistance, etc.

#### iRecord Dropdowns

- Adjusting Water Temperature
- Blowing Nose
- Chewing & Swallowing
- Dressing
- Drinking on own
- Feeding self
- Toileting- Bladder
- Toileting- Bowel
- Using Microwave
- Using Stove
- Washing Hands
- Other

## MEDICAL

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### MULTIPLE FIELDS

**Description:** Gather information necessary to complete each part of the Medical Section.

**Information Needed:**

- Primary Care Physician
- Preferred Hospital
- Managed Care Organization (MCO)
- Diagnosis
- Primary Care Physician Address
- Administrative Service Organization
- Private Insurance
- Additional Specialists
- Vaccination History
- Preferred Pharmacy
- Medication

## DEVELOPING OUTCOMES

Outcomes reflect what the person wants to achieve. They often provide a vision for the future by describing something a person wants to accomplish, change, improve, or maintain in their life. Outcomes express the “end result” of services, supports, and strategies. They are defined by the person and focus on areas including:

- Valued Social Roles
- Employment
- Relationships & Social Connections
- Recreation and Leisure
- Home Life
- Health & Well-Being
- Lifelong Learning

There are some important things to keep in mind when helping the person determine the outcomes s/he wants to achieve. Outcomes:

- Are respectful
- Reflect what the person wants to achieve; his/her vision for life
- Are specific to the person and connect to what is written in the Person-Centered Planning Tool (PCPT) – *Important To* and *Hopes & Dreams* sections must be considered/used when developing outcomes
- Are written in future tense
- Use everyday language, not jargon
- Should be singular, focusing on one area of achievement
- One must be focused on employment
- Do not focus on someone’s “readiness” to achieve something
- Do not reference the disability (not deficit/disability focused)
- Should focus on something anyone would want to achieve regardless of disability
- Are not services
- More outcomes do not = a quality plan

Please see previous examples on pages 14, 16, 19, 23, and 25 for ways that cross-walking can be used to develop outcomes.

## TIPS FOR REVIEWING & REVISING

### Review the Plan Before Seeking Approval

Read through the plan. Ask yourself the following questions:

- If you never met the person, would you have a good idea of who the person is based on reading through the plan?
- Do you know what people like about him/her and understand his/her strengths?
- Would you know what is important in his/her life and be able to help the person do things s/he enjoys in the community? At home? At work?
- Would you feel comfortable being left alone to support the person?
- Do you know his/her preferences?
- Do you know what s/he wants to achieve in his/her life? His/her vision for life?

When reviewing outcomes, always ask yourself...

- Is this what the person wants?
- Does it connect back to information found in the PCPT?

### The Plan is a Living Document that Changes and Grows with the Person

As you work with the person to continually plan, ask yourself the following questions to identify what you still need to learn in order to grow the plan:

- What else do we need to know about the person?
- Who else is in the person's life that may have important information to contribute?
- Are there ways Education, Experiences, and Exposure can be presented to the person to learn more about what s/he may want to do to increase community integration, learn new skills, build social capital, and grow his/her circle of support?
- Are the support strategies currently in place working? Do they need to be changed?
- Are outcomes being addressed? Achieved? Does the person still want to achieve them?

The Monitoring Tool should be used to refine the plan based on progress and changes in the person's life.

## RESOURCES & REFERENCES

### **New Jersey DDD – Support Coordinator Information Webpage**

<https://nj.gov/humanservices/ddd/providers/support/>

### **Administration on Community Living – Person Centered Planning**

<https://acl.gov/programs/consumer-control/person-centered-planning>

### **The Boggs Center on Developmental Disabilities – Developing Person-Centered Outcomes & Strategies**

<http://rwjms.rutgers.edu/boggscenter/publications/documents/DevelopingPersonCenteredOutcomes-final.pdf>

### **The Boggs Center on Developmental Disabilities – Right to a Community Life – HCBS Advocacy Guides**

<http://rwjms.rutgers.edu/boggscenter/RighttoaCommunityLife.html>

### **Centers for Medicare and Medicaid Services – HCBS Final Rule – Federal Register**

<https://www.govinfo.gov/content/pkg/FR-2014-01-16/pdf/2014-00487.pdf>

### **Centers for Medicare and Medicaid Services – Key Message and Tips for Providers: Person-Centered Service Plans**

[https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/key-messages-Person-Centered-Service-Plans-\[September-2015\].pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/key-messages-Person-Centered-Service-Plans-[September-2015].pdf)

### **Centers for Medicare and Medicaid Services – System-Wide Person Centered Planning**

<https://www.medicaid.gov/sites/default/files/2019-12/system-wide-person-centered-planning.pdf>

### **The Council on Quality & Leadership – Personal Outcome Measures**

<https://www.c-q-l.org/the-cql-difference/personal-outcome-measures>

### **Helen Sanderson Associates – Person-Centered Thinking Tools**

<http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/>

### **The Learning Community for Person Centered Practices**

<https://tlcpcp.com>

### **UMKC Institute for Human Development – Charting the LifeCourse Nexus**

<https://www.lifecoursetools.com/>



## CROSS-WALKING FROM NJ CAT

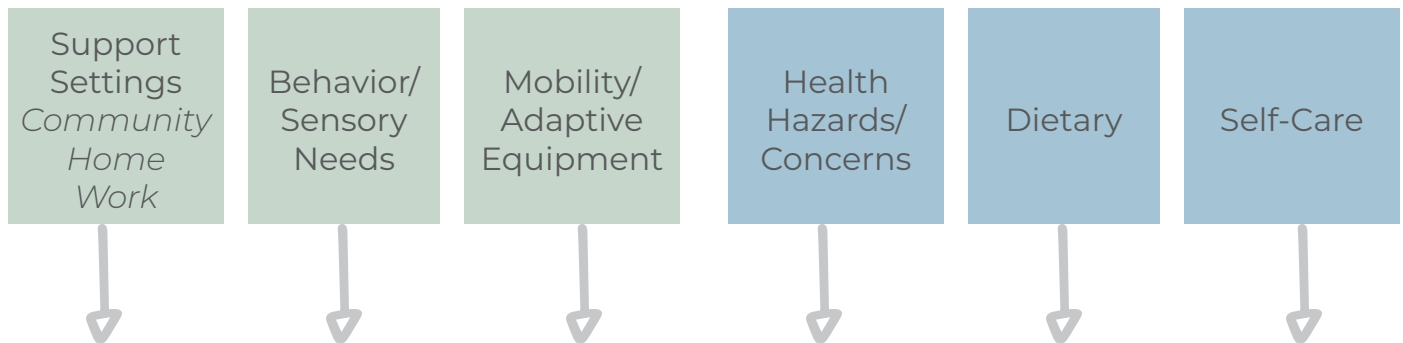
**NJ CAT + Conversations = Providing Details about Support Needs**

**New Jersey Comprehensive Assessment Tool  
(NJ CAT)**

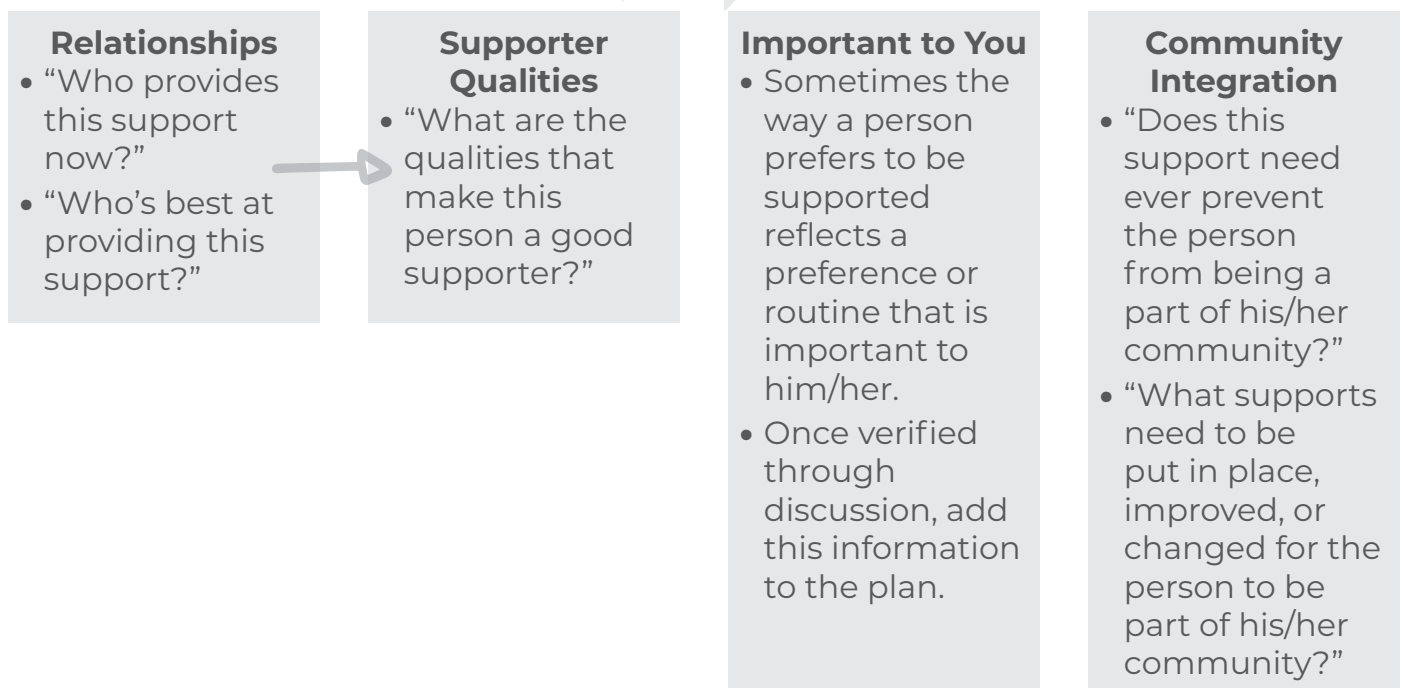
**Have conversations about *HOW* to support the person based on needs identified in the NJ CAT.**

### Safety & Supports

### Health/Nutrition

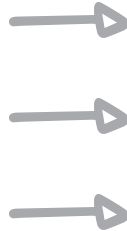


**Discuss and learn more. Ask probing questions to complete additional sections of the plan.**



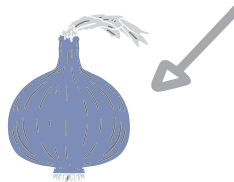
## STARTING WITH THE RELATIONSHIP MAP

Information Gathering Tools + Conversations + Cross-walking =  
Developing the Plan



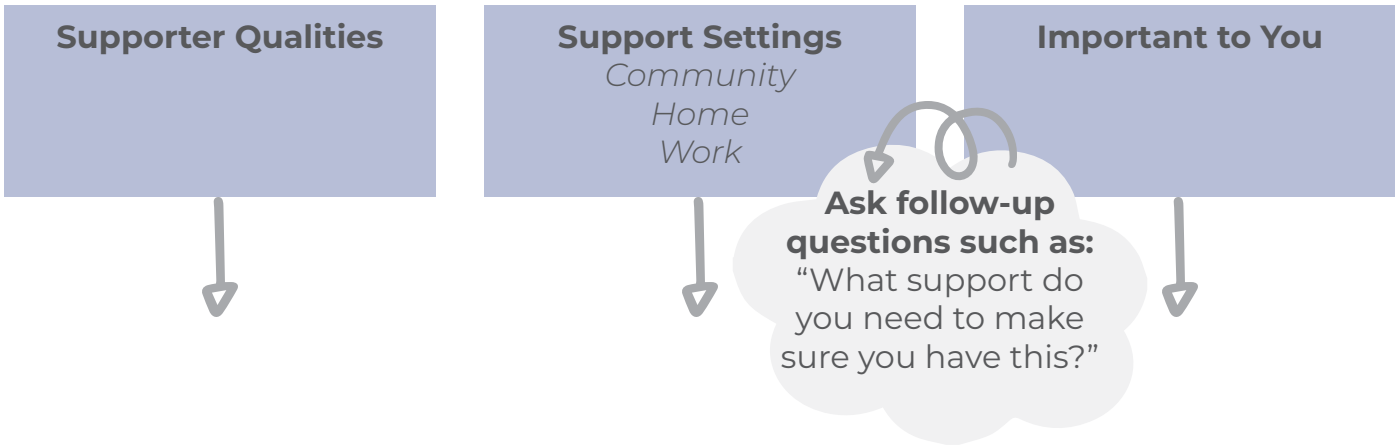
### Ask follow-up questions such as:

- “What do you like best about [...]?”
- “What are some things that [...] does that bother you?”
- “How does [...] help you?”
- “What would happen if [...] weren’t around?”
- “What do you like to do with [...]?”
- “Why do you like [...]?”



### “Peel the onion”

Discuss and extrapolate relevant information.  
Ask additional probing questions as needed.



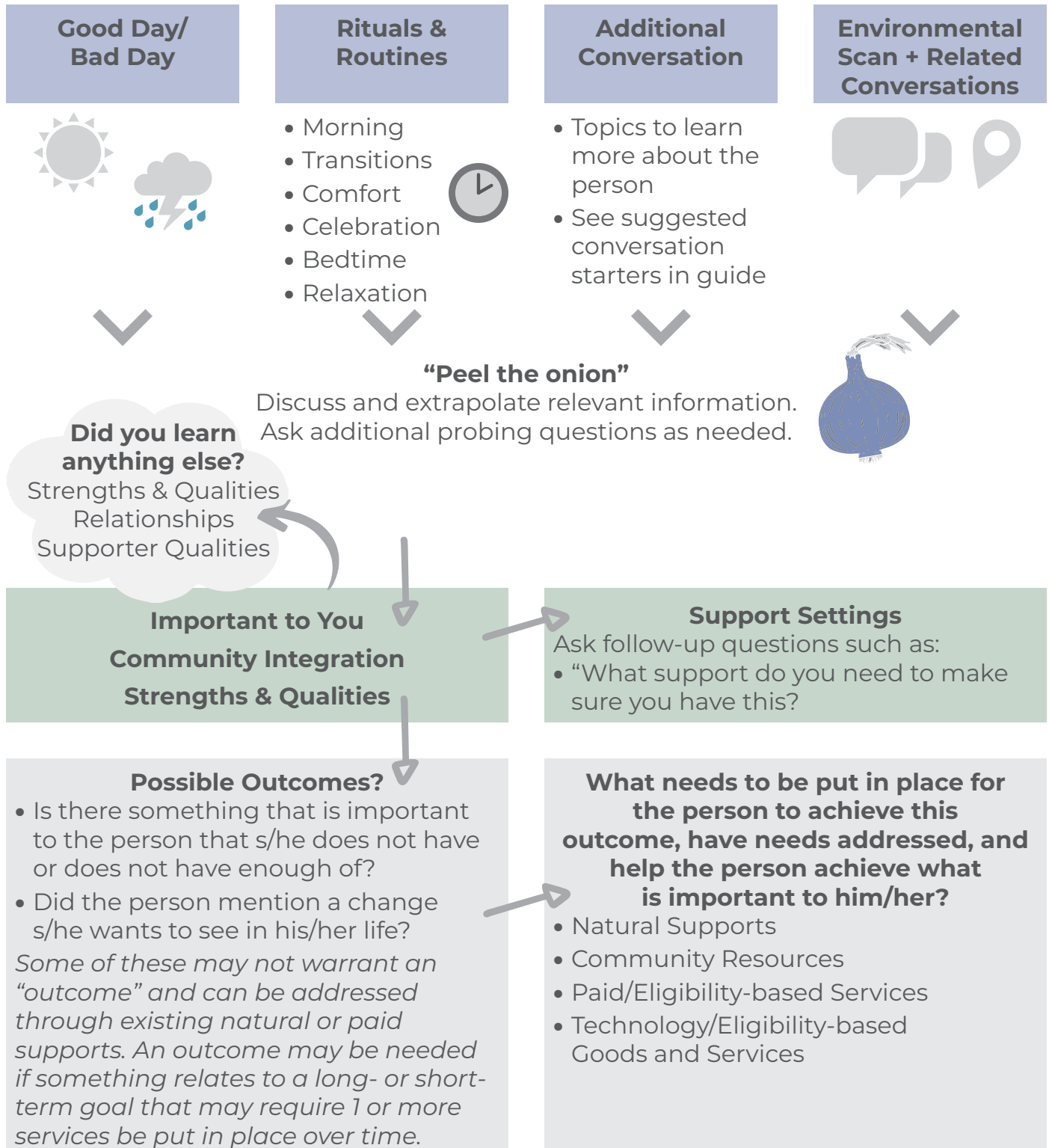
### Possible Outcomes?

- Is there something that is important to the person that s/he does not have or does not have enough of?
- Did the person mention a change s/he wants to see in his/her life?

*Some of these may not warrant an “outcome” and can be addressed through existing natural or paid supports. An outcome may be needed if something relates to a long- or short-term goal that may require 1 or more services be put in place over time.*

## CROSS-WALKING FROM INFORMATION GATHERING TOOLS

**Information Gathering Tools + Conversations + Cross-walking =  
Developing the Plan**





**THE BOGGS CENTER ON DEVELOPMENTAL DISABILITIES**  
*New Jersey's University Center for Excellence in Developmental Disabilities Education, Research, and Service*  
*New Jersey's Leadership Education in Neurodevelopmental and Related Disabilities Program*

# EXPLORING POSSIBILITIES & SUPPORTS: AN INFORMATION GATHERING TOOLKIT

This resource provides people with developmental disabilities, family members, and Support Coordinators with tools to use when exploring life possibilities and planning for supports. The information gathered can be used, together with conversations, to inform the person-centered planning process and development of the Person-Centered Planning Tool and New Jersey Individualized Service Plan.



## INSIDE YOU'LL FIND:

- Relationship Map ..... 45
- Great Things About Me ..... 46
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**THIS TOOLKIT IS ALSO AVAILABLE AT: [HTTPS://RWJMS.RUTGERS.EDU/BOGGSCENTER/PUBLICATIONS/EXPLORINGPOSSIBILITIESUPPORTSANINFORMATIONGATHERINGTOOLKIT.HTML](https://rwjms.rutgers.edu/boggscenter/publications/exploringpossibilitiessupportsaninformationgatheringtoolkit.html)**

### RELATIONSHIP MAP

**Family**

**Supporters at work, school, or other service setting**

**Supporters at home and in the community**



**Friends and Non-paid Relationships**

Based on concepts, principles, and materials by  
The Learning Community for Person Centered Practices: <http://tlcpcp.com>

### GREAT THINGS ABOUT ME

*What are some things the person likes or admires about themselves? What are things others say they like and admire about him/her? What are some of the person's proudest moments?*



### LIKES

*What things does the person like to do? What places does the person like to go?*

### DISLIKES

*What things does the person not enjoy doing? Are there places the person prefers to avoid?*



Based on concepts, principles, and materials by  
The Learning Community for Person Centered Practices: <http://tlcpcp.com>

## RITUALS AND ROUTINES

*Does the person have any specific things that need to happen to feel happy, calm and comfortable? Think about the rhythms, patterns, and routines that make things work best for him/her. Consider rituals and routines in the morning, evening, around transitions between places or activities, celebrations, and religious/cultural practices.*



Based on concepts, principles, and materials by  
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**GOOD DAY**

*What would make for a perfect day? What happens when everything goes right? Where is he/she? Who is there? What is he/she doing? What things happen that really help the person have a wonderful day?*

**BAD DAY**

*What would make for the worst day possible? What happens when everything goes wrong? Where is he/she? Who is there? What is he/she doing? What things really bug the person?*



Based on concepts, principles, and materials by  
The Learning Community for Person Centered Practices: <http://tlccpcp.com>

## HOW THE PERSON COMMUNICATES

*All people communicate feelings without using words. Please share how the person communicates feelings in various situations and offer advice on how others can best support them at those times.*

### **What is happening?**

*What is happening around the person?*

### **What does the person do?**

*What does the person do (expressions, behavior)?*

### **What do we think it means?**

*What is the person trying to communicate?*

### **What should we do?**

*How do we support the person to feel better?*

Based on concepts, principles, and materials by  
The Learning Community for Person Centered Practices: <http://tlcpcp.com>

## LOOKING BACK

### My Story

*What are the pivotal experiences in the person's life that have helped define who they are as a person? These can be happy, sad or otherwise impactful events that helped shape what is most important to the person.*

## LOOKING FORWARD

### My Vision for the Future

*What does the best possible future look like? If no barriers existed, what job or activity would the person want to have during the day? Where would he/she live? Who would he/she live with or be near? What groups and activities would he/she be involved with in the community? What relationships would he/she have?*

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The Learning Community for Person Centered Practices: <http://tlcpcp.com>

## LIFE TRAJECTORY TOOL

Use the Life Trajectory Tool to explore the things that are going well and identify what might be preventing someone from achieving the vision for a good life.

Here's how:

- Record experiences that could help the person move closer toward goals in the space above the arrow.
- Record experiences that might be preventing the person from reaching their goals in the space below the arrow.
- Use the boxes on the right side of the worksheet to record the visions for what the person wants and doesn't want for their life.

The diagram shows a worksheet titled "LIFE TRAJECTORY | EXPLORING". It features a large diagonal arrow pointing from the bottom-left to the top-right. A dotted horizontal line extends from the start of the arrow to the right. On the right side, there are two rounded rectangular boxes: a purple one labeled "Vision for What I Want" and a red one labeled "What I Don't Want". At the bottom left, there are six small icons representing different life domains: a person, a group of people, a person with a cane, a person with a hearing aid, a person with a wheelchair, and a person with a prosthetic arm. At the bottom right, there is a small text credit: "Developed by the Charting the LifeCourse Nexus - LifeCourseTools.com • © 2021 Curators of the University of Missouri | UMKC IHD • September 2021".

Developed by the Charting the LifeCourse Nexus,  
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A full-size version of this tool, tip sheet with further guidance, and video tutorial are available on the Charting the LifeCourse Nexus website:  
<https://www.lifecoursetools.com/lifecourse-library/foundational-tools/person-centered/>

### MAPPING RELATIONSHIPS TOOL

Use the Mapping Relationships Tool to help identify the important people in someone’s life, the ways they provide support, and who may be able to fill those roles in the future when others are no longer able.

Here’s how:

- Explore who the person enjoys spending time with, makes them feel loved, and knows them best in the **Caring About** section.
- Identify those who help meet the person’s needs in the **Caring For** section.
- Use the columns to record those who currently serve in a role, who may do so in the future, and any next steps for maintaining or building new relationships.

MAPPING RELATIONSHIPS

CARING ABOUT	Who serves in this role now?	Looking Ahead	Next Steps
Shares Love, Affection and Trust			
Spends Time and Creates Memories Together			
Knows about Personal Interest, Traditions, Cultures			

CARING FOR	Who serves in this role now?	Looking Ahead	Next Steps
Supports Day-to-Day Needs			
Ensures Material and Financial Needs are Met			
Connects to Meaningful Relationships and Roles			
Advocates and Supports Life Decisions			

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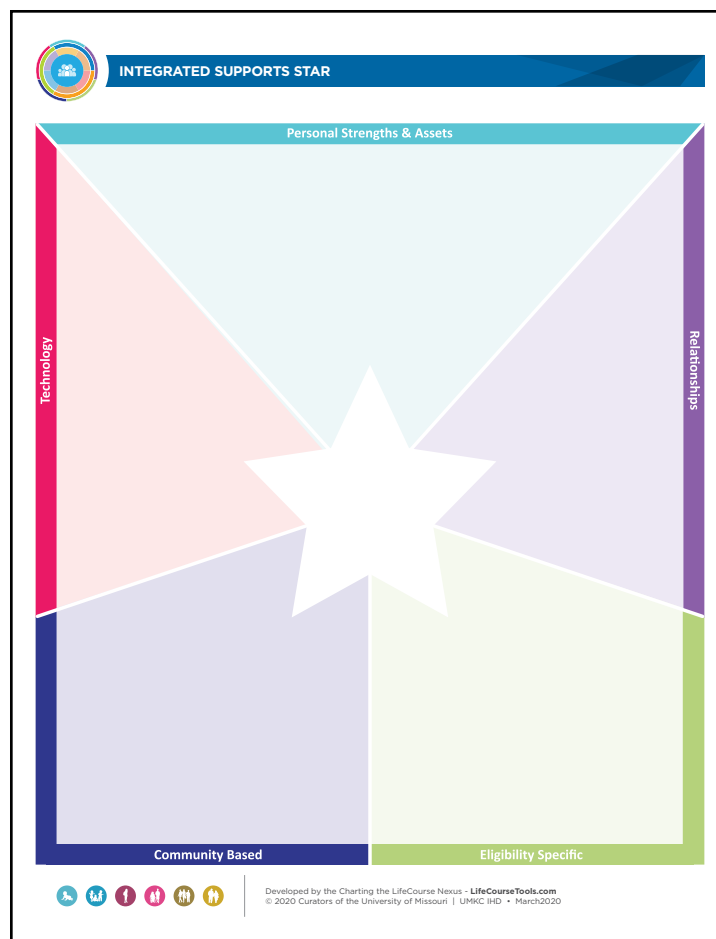
A full-size version of this tool and tip sheet with further guidance are available on the Charting the LifeCourse Nexus website:  
<https://www.lifecoursetools.com/lifecourse-library/foundational-tools/person-centered/>

## INTEGRATED SUPPORTS STAR

Use the Integrated Supports Star to help someone map out current services and supports, problem solve around a specific need, or plan for next steps.

Here's how:

- Decide on the purpose for using the Star.
- Record the person's name in the center if you are mapping supports or the issue or goal if problem-solving.
- Record ideas or resources in each section of the star to capture how needs are or can be met using a variety of supports.

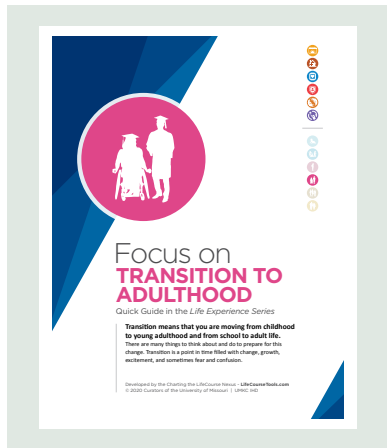


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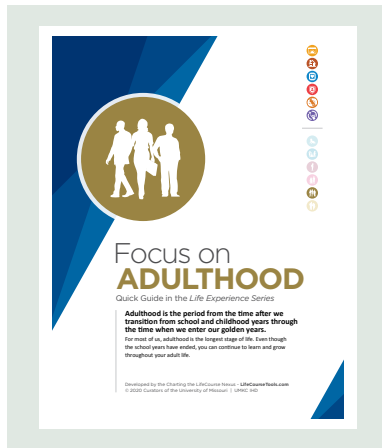
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<https://www.lifecoursetools.com/lifecourse-library/integrated-supports-star/>

**QUICK GUIDES IN THE LIFE EXPERIENCE SERIES**

Quick Guides in the Life Experience Series provide questions to ask, options to consider, and things to discuss during specific life stages.



**Focus on Transition to Adulthood** offers questions to help guide planning for the move from childhood to young adulthood and from school to adult life.



**Focus on Adulthood** provides questions to help someone continue and grow throughout adulthood, the longest stage of life.



**Focus on Aging** provides questions to make choices and guide planning for experiences that make later life enjoyable and productive.

Quick Guides in the Life Experience Series are available on the Charting the LifeCourse Nexus website:

<https://www.lifecoursetools.com/lifecourse-library/exploring-the-life-stages/>

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# Developing Person - Centered Outcomes

Outcomes reflect what the person wants to achieve. They often provide a vision for the future by describing something a person wants to accomplish, change, improve, or maintain in their life. Outcomes express the "end result" of services, supports, and strategies. They are defined by the person and focus on areas including:

						
Valued social roles	Employment	Relationships & Social Connections	Leisure & Recreation	Home life	Health & Well-being	Lifelong learning

## Identifying Outcomes

Support Coordinators work with the person to determine what they want to achieve in their life by using a Person-Centered Planning Process that involves:

- Having conversations with the person and those who know him/her well
- Learning about what is important to the person and his/her desired future
- Considering all areas of life and common categories listed above



## Tips for Writing Outcomes

When writing outcomes, remember that outcomes:

- Reflect what the person wants to achieve; his/her vision for life
- Are specific to the person and connect to what is written in the Person-Centered Planning Tool (PCPT)
- Are written in future tense
- Use everyday language, not jargon
- Should be singular, focusing on only one area of achievement
- One must be focused on employment
- Do not focus on someone's "readiness" to achieve something
- Are not services



## Do's and Don'ts



Do focus on achievements that are specific to the person.

Ex: Joe will get a job where he can use his computer skills.



Don't focus on the disability or readiness to achieve something.

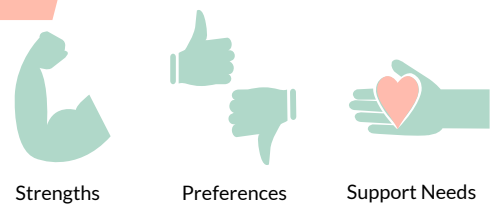
Ex: Joe will reduce his challenging behaviors so he can participate in community activities.





# Developing Person - Centered Support Strategies

**Person-Centered Support Strategies** are the actions and tasks completed by service providers when helping a person achieve the outcomes they want in life. Strategies are informed by the person's strengths, preferences, and support needs. These will change as the person changes, achieves what they hope to, and chooses new outcomes they'd like to focus on.



### Developing Person-Centered Support Strategies

Service providers work with the person, the support team, and others who know the person best to develop strategies that will help them to achieve outcomes by:

- Working in collaboration with the person, Support Coordinator, and team to become familiar with the person's vision, support needs, preferences, and the outcomes they have defined using the Person-Centered Planning Tool (PCPT) and Individualized Service Plan (ISP)
- Listening deeply to the person and others who know them well
- Making thoughtful observations of the person at home, around others, at work, and in the community

### Tips for Developing Strategies

When developing strategies, remember that person-centered support strategies:

- Are planned and implemented in response to the outcomes the person wants to achieve
- Address the person's interests, preferences, and support needs
- Consider paid supports, unpaid supports, and resources in the community that will be utilized in reaching outcomes
- Are not services, but rather the actions involved in providing services

There may be multiple support strategies in place to achieve one outcome.

## The Outcome: Janet will become a member of her local art center.

**DO**

### Do's and Don'ts

**DON'T**

Do list the strategies involved in helping the person achieve an outcome.

Ex: A Direct Support Professional will role play with Janet to help her navigate social situations more effectively.

Don't list the service as the support strategy.

Ex: Janet will receive Community-Based Supports.

May 2018



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# PERSONAL OUTCOME MEASURES<sup>®</sup>



## MY HUMAN SECURITY

1. People are safe
2. People are free from abuse and neglect
3. People have the best possible health
4. People experience continuity and security
5. People exercise rights
6. People are treated fairly
7. People are respected



## MY COMMUNITY

8. People use their environments
9. People live in integrated environments
10. People interact with other members of the community
11. People participate in the life of the community



## MY RELATIONSHIPS

12. People are connected to natural support networks
13. People have friends
14. People have intimate relationships
15. People decide when to share personal information
16. People perform different social roles



## MY CHOICES

17. People choose where and with whom to live
18. People choose where they work
19. People choose services



## MY GOALS

20. People choose personal goals
21. People realize personal goals



[www.c-q-l.org](http://www.c-q-l.org)



## Assisting People with Developmental Disabilities to Advocate

The **Home and Community Based Services (HCBS) Settings Final Rule** is a federal policy change announced by the Centers for Medicare and Medicaid Services (CMS) in January 2014 to make sure that people with disabilities have the kinds of services they need in their communities. The Rule sets requirements for **where** and **how** Medicaid HCBS are provided to ensure that people receiving services through Medicaid HCBS waiver programs have full access to community life. This means that services should be provided in the most integrated setting possible, and must provide opportunities for **integration and access to the community, choice, individual rights, and independence.**

Throughout the planning and implementation process to comply with the Rule, states will ask stakeholders for input about the services they receive, the places where services are provided, and changes that could be made to help them get the community lives they want. Some people with developmental disabilities may need assistance to think about how their services could better support them in their communities and to advocate for their right to a community life.

This resource prepares you to assist those you support to advocate for the community lives they want and share their experiences receiving Home and Community Based Services.

## Step 1: Learn About the HCBS Settings Final Rule

Before you support someone to advocate, you will want to learn more about the HCBS Settings Rule yourself. A reader-friendly HCBS Settings Rule 3-Part Toolkit was created by the national HCBS Advocacy Coalition. The toolkit covers what you should know about the Rule and provides guidance on how to advocate for truly integrated community settings. The toolkit, along with other national resources, can be accessed on the HCBS Advocacy website:

<https://hcbadvocacy.org/national-resources/>

## Step 2: Help Those You Support to Think About Their Lives and Their Services

The Rule is designed to make sure that HCBS services provide people who receive them with opportunities to participate in the community, make choices, have individual rights, and be independent. You should review the concepts of integration and access to the community, choice, individual rights, and independence with the person you support. Make sure the person you support understands these key concepts by asking them to provide their own definitions and examples, and offering clarification as needed. You can find definitions and examples for each of the concepts to help guide this conversation in *Your Right to a Community Life: A Guide to Home and Community Based Services Advocacy*, available online at the following address:

<http://rwjms.rutgers.edu/boggscenter/RighttoaCommunityLife.html>

In addition to making people aware of their rights, supporters have an important role in helping to determine if these rights are being realized. You should have a conversation to determine whether the services the person receives provide opportunities for inclusion, choice, and independence, and whether advocacy is needed. It's important to ask, listen, and observe to learn what the person you support really wants for their community life. Here are a few tips for having this conversation:

### ASK

Ask open-ended questions about **integration and access to the community**, **choice**, **individual rights**, and **independence** to help the person you support determine whether the services they receive comply with the requirements of the Rule, and where advocacy is needed. Before you begin, make sure the person you support knows why you're having this conversation and how the information will be used. Suggestions for questions to help guide this conversation are listed below and on the next page.



### Integration and Access to the Community

- What opportunities do you have to spend time in places where other people living in your community go? (examples: stores, restaurants, bank, house of worship)
- What kinds of interactions do you have with people in your community? (examples: visit with neighbors, attend meetings of clubs or religious groups, order food in restaurants)
- How do your service providers support you to do what you want in your community?
- Do you get to do as much as you want in your community? If so, what are the things you are supported to do? If not, what would you like to do that you aren't doing now?

## Step 2: Help Those You Support to Think About Their Lives and Their Services (continued)

### Choice

- How did you choose where to live and who would live with you? What options did you have to choose from? Do you have your own lease?
- How did you choose where to work? What options did you have to choose from?
- How did you decide who would provide your services?
- Are you happy with where you live, work, and receive services? If not, what changes would you make?

### Individual Rights

- What do you know about your rights as someone receiving services?
- Are there things you want but don't have? If so, what are they and why can't you have them?
- Have there been times when you felt you were not being treated fairly? If so, what happened to make you feel this way?
- How do you know if your opinions are valued and respected?

### Independence

- What kinds of decisions do you make?
- What kinds of things do you choose to do for fun in your community? How often? Who do you go with?
- What kinds of things do you decide to spend your money on?
- Is there anything that would make it easier for you to get around your home, school, workplace, or community?
- Is there something you wish you could do, but can't? If so, what's the reason?

## LISTEN

Listen to the person you support as they respond and probe for more detail by asking for examples of how their services do or do not provide the opportunities they want to be part of their community.



## OBSERVE

Keep in mind that the person you support may be telling you what they think you want to hear. Pay attention to signs that might show the person you support feels differently than what they are telling you. This could be through body language or wanting to change the subject quickly. You should reassure the person you support that the information they share will help to inform changes needed to their services and the services of others with developmental disabilities, and will not be used against them.



## Step 3: Assist with HCBS Advocacy

The Home and Community Based Services (HCBS) Settings Final Rule has created many opportunities for advocacy. Stakeholders might be asked to provide their input through discussions with service providers and/or support coordinators, by providing public comment, or testifying at hearings. You can assist the person you support to advocate for the community life they want by helping them to:

- prepare for sharing their thoughts at a team planning meeting with service providers, case managers, support coordinators, and others who know them well
- draft testimony to present at public hearings or submit during comment periods
- call an advocacy organization or policymaker
- connect with others interested in HCBS advocacy

## Step 4: Find Organizations That Can Help

If the person you support feels their rights are being restricted, or not respected, you should help them determine if they need to talk to the Human Rights Committee for the organization providing services.

There are also organizations you can help the person you support to contact if they feel like their rights are being violated. In each state, there is a **Disability Rights/Protection and Advocacy System** to provide legal representation for individuals with disabilities, a **Developmental Disabilities Council** to work toward change with stakeholders and advocates, and a **University Center for Excellence in Developmental Disabilities (UCEDD)** to provide training, technical assistance, and information. To learn more about these programs and to find contact information for the ones in your state, visit:

<https://www.acl.gov/about-acl/administration-disabilities>

This resource was developed by The Boggs Center on Developmental Disabilities, New Jersey's University Center for Excellence in Developmental Disabilities Education, Research, and Service, in collaboration with CQL | The Council on Quality and Leadership and the Illinois Council on Developmental Disabilities.

Some items found in this resource were adapted from: The Council on Quality and Leadership (2017). *Personal Outcome Measures®: Measuring Personal Quality of Life*.

January 2018





# THE BOGGS CENTER ON DEVELOPMENTAL DISABILITIES

*New Jersey's University Center for Excellence in Developmental Disabilities Education, Research, and Service*

*New Jersey's Leadership Education in Neurodevelopmental and Related Disabilities Program*

## DEVELOPING EFFECTIVE PERSON-CENTERED PLANNING TOOLS & NEW JERSEY INDIVIDUALIZED SERVICE PLANS

This document was developed in collaboration with and supported in part by the NJ Department of Human Services, Division of Developmental Disabilities.

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