Living Well In My Community

Part 4:
Planning My Good Life

How to use Living Well In My Community

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

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

HCBS Peer Partners Project Grant

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

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

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

Acknowledgments

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

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

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

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

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

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

May 2020

Contents

Part 4: Planning My Good Life

Person-Centered Planning

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

Connie Lyle O'Brien and John O'Brien

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

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

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

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

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

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

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

Planning will help the person think about things like:

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

Planning My Good Life

Person-centered planning is an ongoing process.

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

The Planning Team

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

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

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

The Planning Team is especially helpful when:

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

Getting Started with Person-Centered Planning

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

HOW TO DO IT

SKILL: Relationship map

What it does

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

How it helps

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

How to use it

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

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

2. Find out who to listen to.

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

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

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

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

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

Working With a Planning Team

SKILL: Relationship map

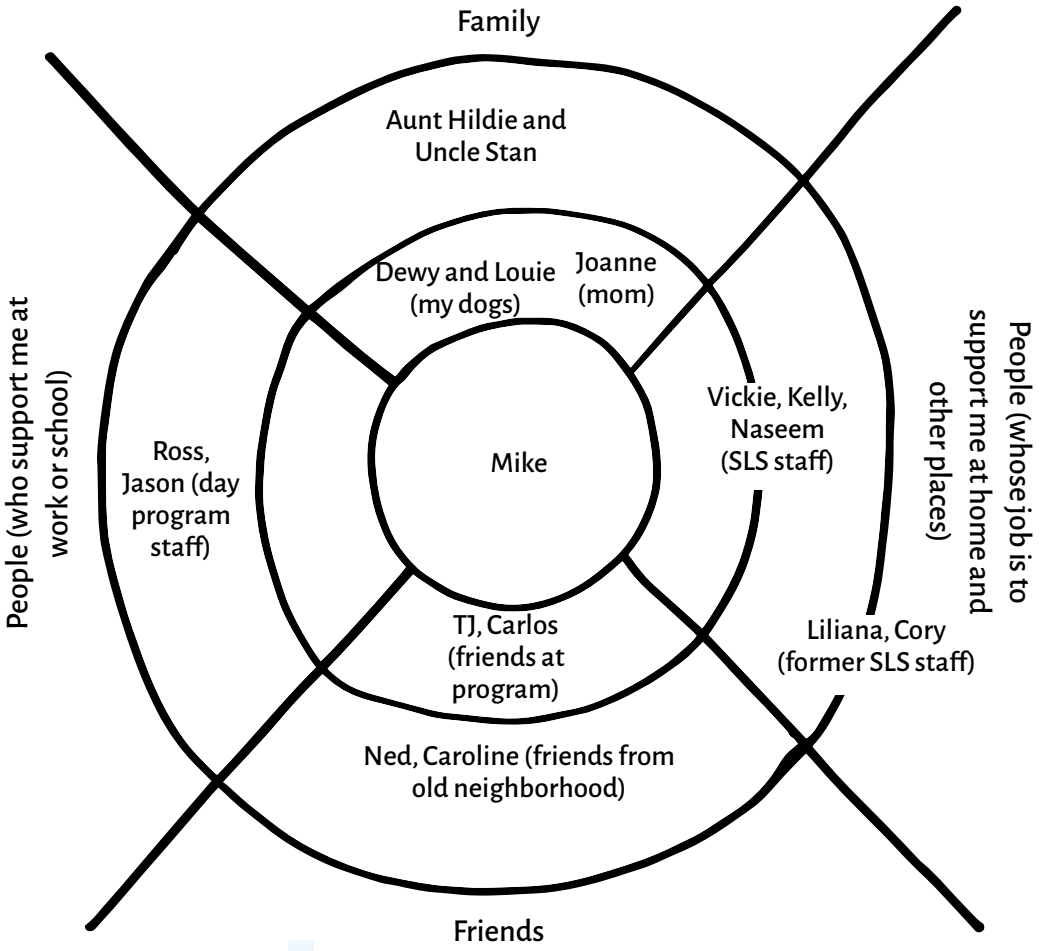
SHARING STORIES

Mike

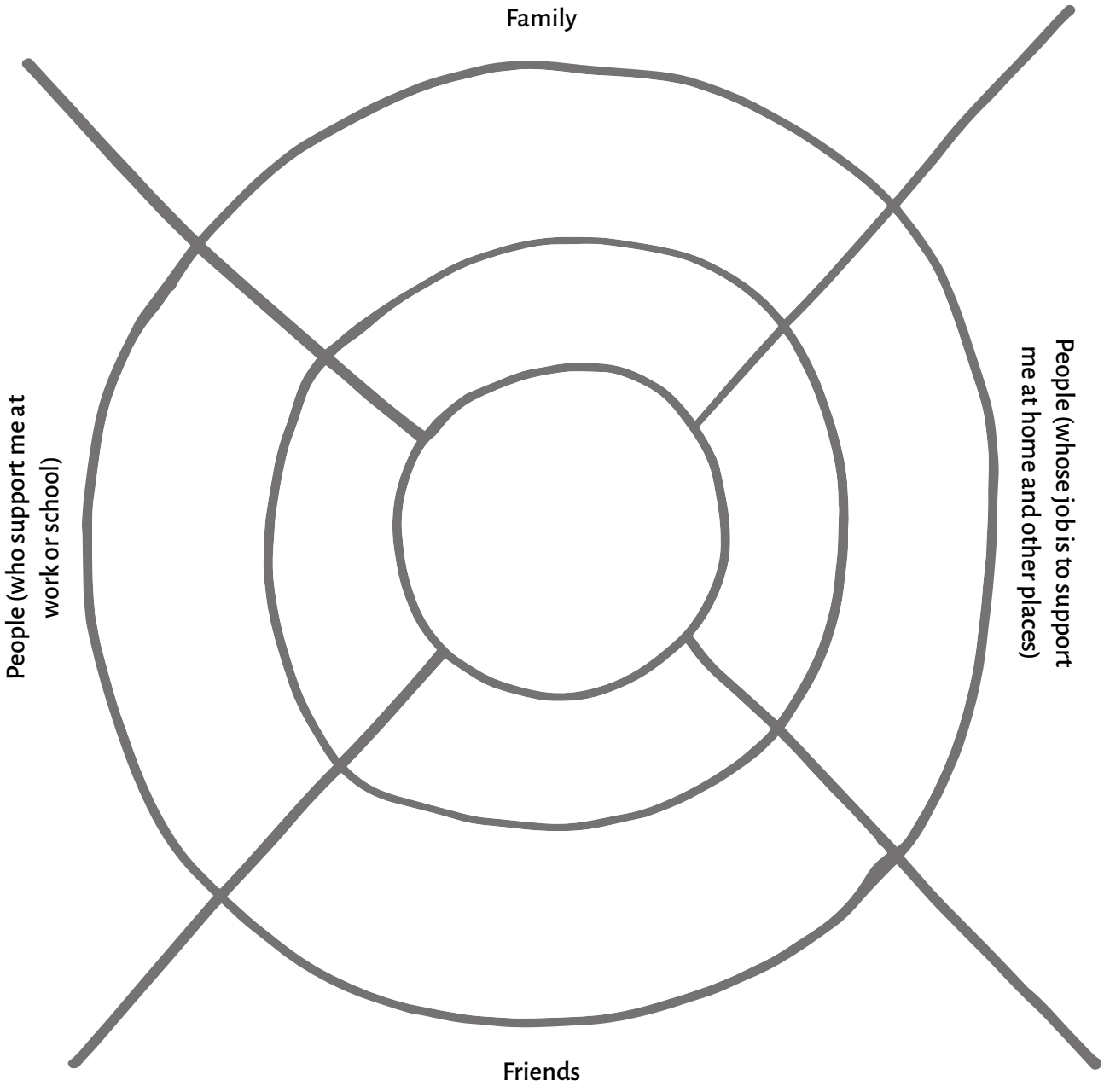
Mike had recently moved into his own residence with supported living services that he shared with friends in a city that was new to him. As a part of his Person- Centered Planning meeting he, his mother and his support team completed a Relationship Map. His current day program and supported living staff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

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

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



SKILL: Relationship map



Working With a Planning Team

Working with a Planning Team

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

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

Planning Team meetings

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

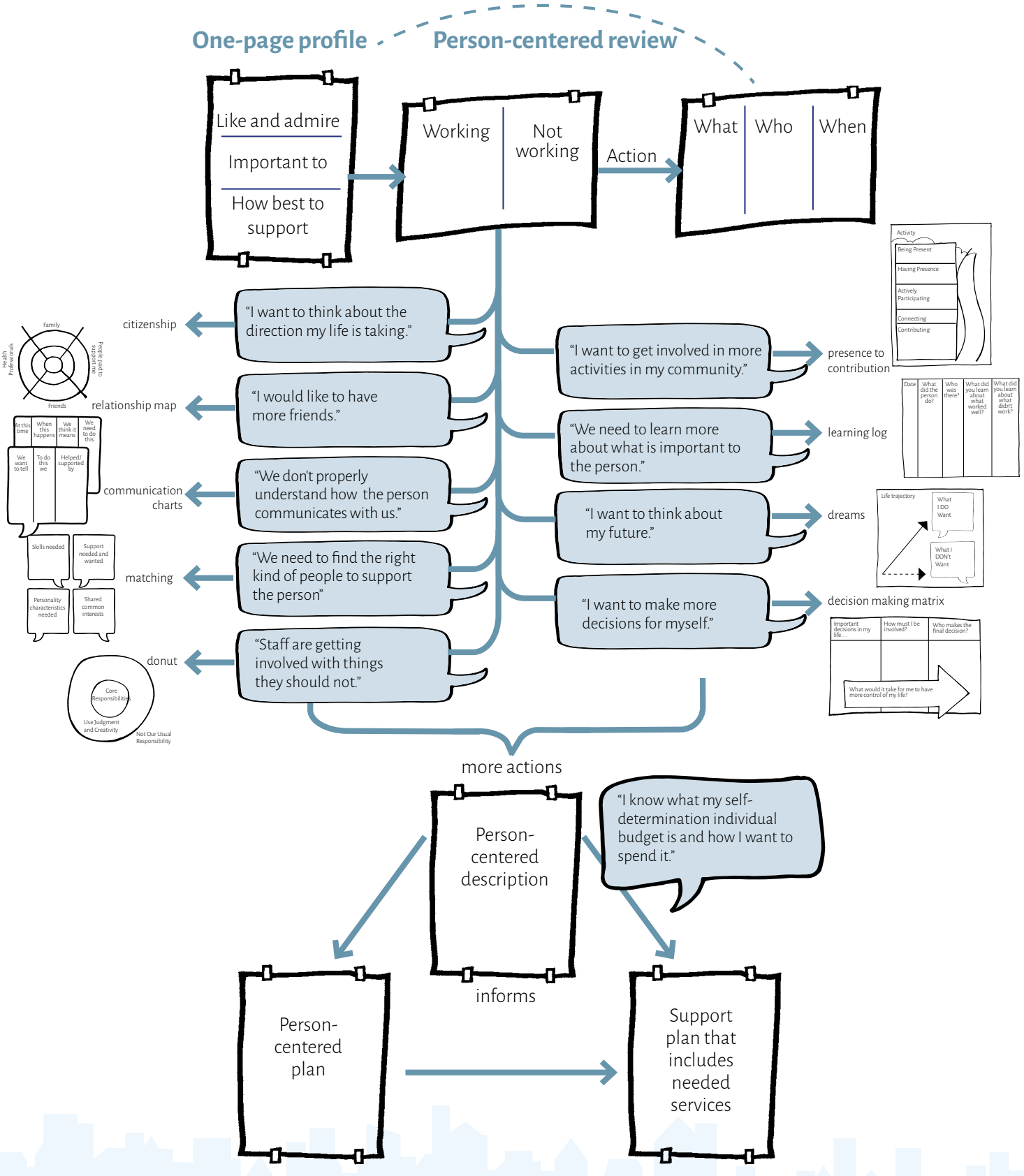
1. The person receiving support will decide on a purpose, agenda, time and place for meeting. Sometimes, the person may invite others to help with these logistics.
2. Create a welcoming environment. If meeting in person, consider light hospitality and arranging a room that is comfortable and not too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

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

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

Working With a Planning Team

From one-page profile to person-centered plan



HOW TO DO IT

SKILL: Working / Not Working

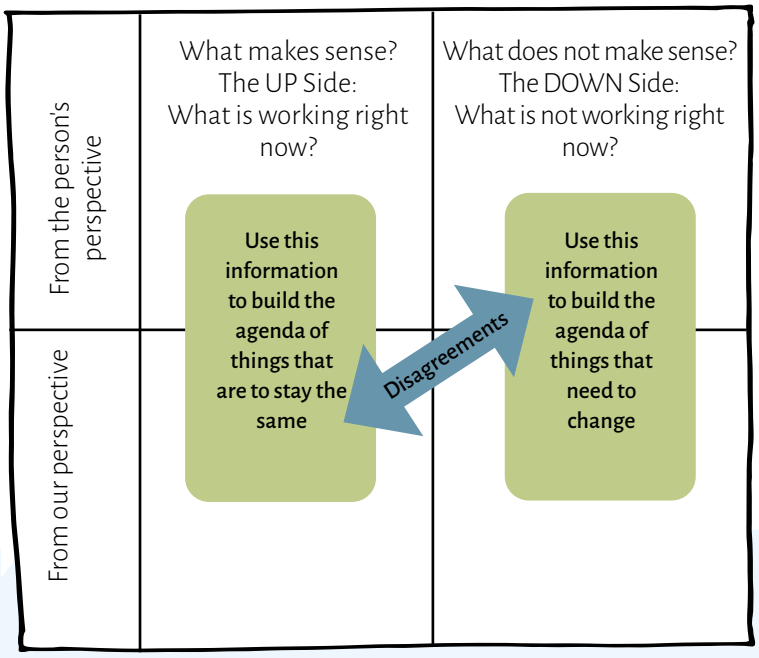
The Working / Not Working skill is a helpful way to start a person-centered planning conversation, or sort through issues with a planning team. It can help in recognizing those things that are working and need to remain the same, and those things that are not working and need to change.

What it does

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

How it helps

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



How to use it

Facilitation of this skill involves several steps:

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

SKILL: Working / Not Working

SHARING STORIES

Katarina

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

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

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

SHARING STORIES

SKILL: Working / Not Working

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

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

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

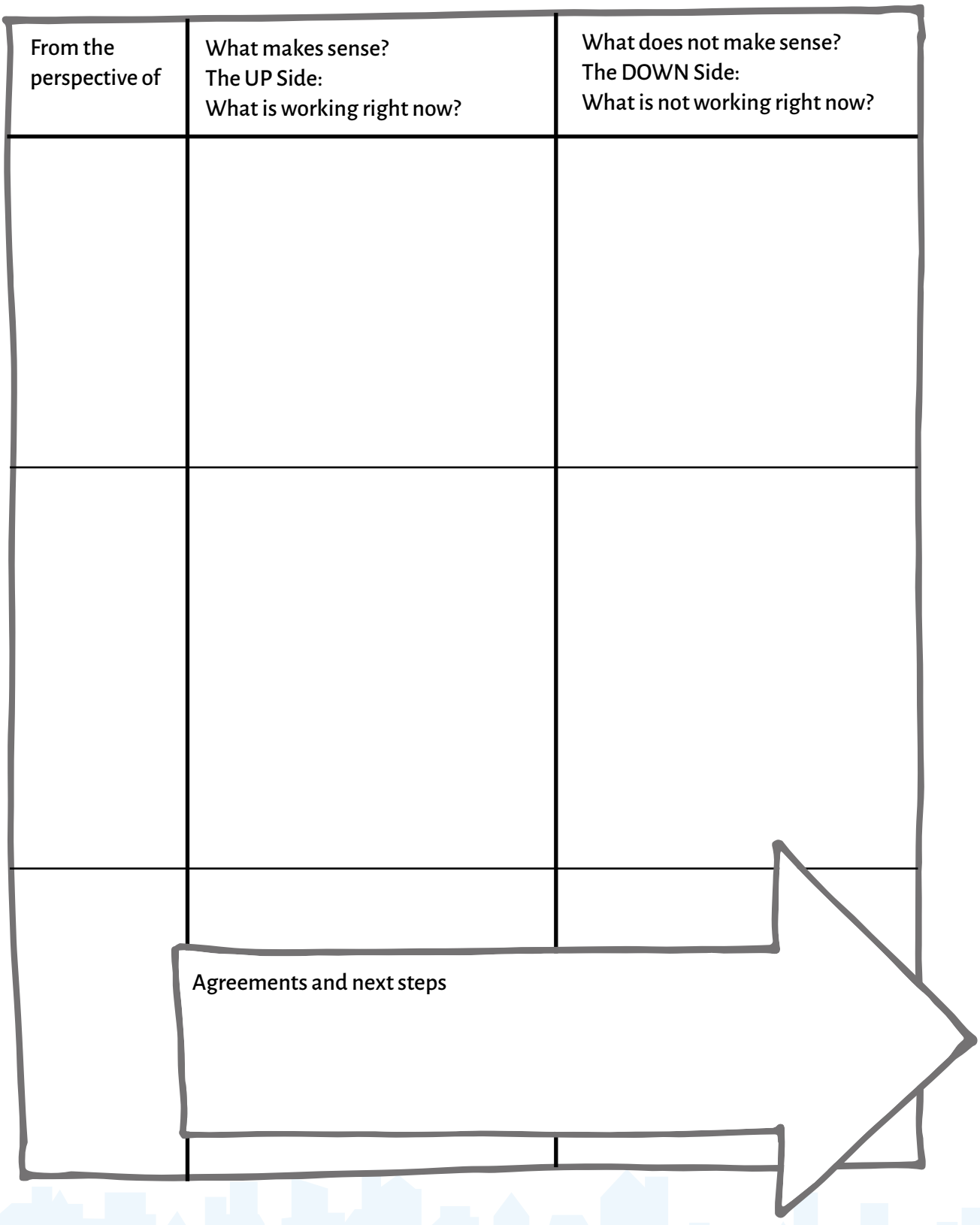
Agreements and next steps

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

Person-Centered Planning

SKILL: Working / Not Working

With respect to



Community Building Checklists

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

Rate the following statements as follows

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

Relationships with family, neighbors, community

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

Community Building Checklists

Members of the community

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

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

Advocacy for, with, on behalf of

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

Community Building Checklists

Fulfilling Hopes, Dreams and Aspirations

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

Now

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

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

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

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

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

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

Helpful websites

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

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

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

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

Inclusion Press
https://inclusion.com/

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

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

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

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

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

Resources

HCBS Resources

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

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

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

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

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

Person-Centered Planning instructional video clips

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

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

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

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

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

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

Information on specific Person-Centered Thinking Skills

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

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

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

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

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

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

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

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

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

Things I want to remember

Things I want to remember


HCBS Peer Partner Project
UCP
WORK, Inc.
BDS
The Learning Community
Tri-Counties
Regional Center
helen sanderson
associates
USA