# Creating Person-Centered Support Plans

TIPS & GUIDELINES

# General Tips :

- Remember it is the person's document and should be written in a way that is useful to him/her (e.g. reading level, language, etc.).
- If the person's name was removed, would you be able to tell who it was about? Each person's support plan should be unique to him/her.
- What image are you portraying about the person to others who see the support plan (e.g. providers, family members, etc.)?
- People should not be defined by their medical issues or diagnoses. Instead consider what is important To and For the person.
- How does this support plan align with current or needed services and supports?
- What would you want your support plan to say about you?

# Goals

- What does the person hope will be the outcome of the supports provided to them? What is the role of the person, the case managers, and service providers in helping the person achieve goals.
- Think long term. This may be something that will take several steps to achieve.
- Think short term. What is something that can be done soon that will provide the person with a sense of pride and accomplishment?
- Think about aspirational dreams. If the person could have or do anything in this world, what would it be?
- What services or supports (formal and informal) might help the person achieve his/her goals? What referrals can be made?
- Think about what they might want to do in order to avoid further health complications or the need for more support.
- Person-Centered Example of Goal:
  - "I would like to continue with high school, graduate, and go to college. I am interested in a career as a ultrasound technician"
  - "She would like to increase the strength in her legs, reporting that this is the strongest part of her body. She will work with her physical therapist weekly to build strength and avoid the need for more care"
  - "I would like to live in my own apartment without roommates someday. I would like my apartment to be near my family and job"

# Choice

- Provide the person with information on how to appeal the services and supports in their CSSP.
- Acknowledge what the person wants and acknowledge possible risks involved with those preferences.
- Ask the person what he/she wants for services and supports. This will spark creative options and that the person is not limited to a small number of providers or procedure codes.
- Document the choices made in the CSSP to ensure providers know about and honor those choices. For example, if the person prefers to have privacy and chooses to not interact with others, it is their choice to do so.
- Person-Centered Example of Choice:
  - "While her long-term goal is to live in her own apartment, she reports that there are skills she needs to strengthen before taking this step. If she should move, access to 24hrs support and staff with mental health experience would be beneficial"
  - "I need assistance with making meals. I have chosen to receive Mom's Meals instead of daily home delivered meals as to not interrupt my daily routines"
  - "I prefer to not participate in group activities. Instead, I would like a staff at my assisted living to come to my apartment weekly to play cards"

# Preferences

- How does the person want to live? Where do they want to live? Who do they want to live with? How does the person want to spend his/her leisure time? What activities or community organizations does he/she want to be a part of? Who does he/she enjoy spending time with?
- What type of employment does the person want?
- What services, supports, and referrals can be made to help the person move towards their preferred employment, living, and leisure outcomes?
- What are the person’s preferred means of communication (e.g. tone of voice, language, etc.)? How can the person’s preferences inform others working directly with the person?
- For example:
  - “I want to get a year-round job working at a coffee shop or café”
  - “I prefer to have a bath or shower every day. I prefer to use the orange soap and organic shampoo”
  - “I want to participate in my church bible study weekly”

# Strengths

- Focus on achievements and contributions to larger society.
- It is about the individual strengths that they possess internally, not necessarily about the external relationships they have.
- Reference to personal characteristics, talents, hobbies.
- What would those closest to this person say is the best thing about them?
- Think about positive things that would make someone want to get to know this person more.
- For example:
  - “She is creative and likes picking out her own clothing. She is good at coordinating and matching outfits”
  - “She values her family relationships and works hard to keep in touch with her family who live far away”
  - “She works hard to be educated on current world issues and enjoys discussing current events with others. She channels her energy into modifying daily activities to allow her to be as independent as possible”

# Important To

- What does this person need to content and happy in their daily life?
- Think specific and unique.
- How is this different for this person compared to others?
- What is that can make this person have a great day compared to a bad day?
- This can include relationships, hobbies and other interests.
- This is not about medical issues or services and supports (diagnosis, ILS services, etc.).
- For example:
  - “It is important to him to spend time with his older brother when he visits every June”
  - “It is important to him to have activities to do that allow him to express his feelings in a creative manner”
  - “It is important to me that I have time to myself every day”
  - “It is best if I have my coffee before I interact with staff or housemates since it helps me to relax and be prepared for the day”

# Description of Assessed Needs

- If I did not know this person and was just observing them, how would I know they need assistance and what would they need assistance with?
- Think about how this person is being portrayed with the words being used. Be aware of tone you are setting, stick to the facts.
- Detailed and specific is helpful.
- Outline the assistance needed from those providing care, including formal and informal supports.
- Avoid jargon, such as medical terminology or acronyms (e.g. 'ADLs' or 'IADLS').
- For example:
  - "She reports that while this mattress is better for her body, she is not able to swing her legs out of bed and requires her caregivers to assist with this"
  - "John needs assistance from his caregivers with dressing his lower body. John will pick out his clothing and provide verbal cues on how he prefers to be dressed"
  - "I need help with scheduling and attending doctor appointments. I would prefer that my husband help me with these tasks instead of paid caregiver"

# Health and Safety

- Be aware of health or safety issues that the person may or may not want described in a support plan that will be shared with others.  Describe health and safety around private activities in a respectful way.
- Incorporate health and safety items that may not be related to HCBS waiver services but interface with other services such as mental health or chemical health.
- Acknowledge the dignity of risk, even when the person chooses to not accept a service that is being recommended to protect their health and safety.
- Reference medical issues and the related safety risks it might pose. How will services and supports outlined in the plan address these health and safety risks?
- For example:
  - "He has several health issues that could result in him choking while eating. Therefore, those working with him will be aware of his medical conditions and will be trained in CPR. They will also remain within close proximity when he is eating."
  - "I sometimes forget to take my medications if I don't have a reminder, which has resulted in seizures in the past. I would like to try a medication dispensing machine to help with this. My nurse will fill the machine every other week during her visits"
  - "I have a history of using alcohol in excess during stressful times in my life. I am aware of the interactions this can have with my medication and the other risks involved, but am not interested in quitting at this time. I will let my case manager know if this becomes of interest to me in the future"

# Challenging Behaviors

- While challenging behaviors that occurred in the past may be interesting, they may not be relevant any longer and therefore may not need to be in the current support plan.
- How does the person want their services and supports delivered? Document ways in which supports could be delivered that will mitigate challenging behaviors.
- Think about your most embarrassing habit or behavior. How would you want that described in a document that is shared with others?
- Describe challenging behaviors in a respectful way that treats the person with dignity
- For example:
  - "It is helpful for her to have reminders from others regarding how to dispose of sanitary products in a healthy and safe manner"
  - "A change in plans or routine can be very upsetting to John. It is helpful for staff to stick to routines as much as possible, and when plans do change, to let John know as soon as possible. It is also helpful to provide choices to John when there is a change in routine"
  - "I can become frustrated if I feel my housemates are not respecting my privacy. In the past, this has led to physical aggression towards others. It is helpful to me if staff in my home are available to calm me down if I start to raise my voice at a housemate"

# Risk Management

- If risk is mentioned, make sure the support plan documents how it will be addressed and/or mitigated and who will play a role in that (e.g. the person, providers, etc.).
- The plan to address risk may be acknowledging that while others disagree, the person has the right to take risks and make his/her own choices.
- If a guardian exists, it is important to still acknowledge what the person wants, despite anyone who may disagree.
- For example:
  - "She currently chooses to stay in contact friends who historically have had altercations with others. It is important that providers and caregivers work with her to develop a safety plan for if/when she feels she is not safe."
  - "Sara is at risk of falls due to poor balance. Although Sara's team has suggested she use a cane when walking in her apartment, she has decided that she is not interested at this time. Sara has agreed to wear a personal response pendent so in the event of a fall she could call for help"
  - "My doctor has recommended that I quit smoking for health reasons. I am aware of the risks to my health but at this time I am not interested in quitting smoking. I will continue discussions with my doctor and ask for help if I decide I want to quit"