Putting People at the Center of the Practices
Reminders

1. Participants will be muted during this webinar. You can use the chat feature in Zoom to post questions and communicate with the hosts (chat “To Everyone” for all to see).

2. Toward the end of the webinar, our speakers will have an opportunity to respond to questions that have been entered into chat.

3. The webinar is being live captioned in English.

4. Attendees may receive 1.5 Continuing Education Credits. To confirm attendance, please login to the webinar via your Zoom account.

5. The live webinar includes polls and evaluation questions. Please be prepared to interact during these times.

6. This webinar is being recorded. The recorded webinar will be available at www.hsri.org/nd-pcp within two weeks, along with a PDF version of the slides, and questions and responses.
Agenda

10:30 - 10:40 Welcome
Jake Reuter and Pamela Sagness

10:40 - 11:10 Presentation
Jennifer Turner

11:10 - 11:15 Break

11:15 - 11:20 Welcome Back

11:20 - 11:55 Panel of Individuals with Shared Experiences
Alisha Owens, Lindsay Schuh, Shannon Strating and Shannon VandeVenter

11:55 - 12:00 Closing + Next Steps
Welcome

Pamela Sagness

Executive Policy Director, Behavioral Health Division

• Responsible for identifying service needs and activities in the state’s behavioral health system.

• Works with partners to address behavioral health needs across the continuum from prevention to recovery.

• Experience as a clinical provider in both the public and private sectors informs her development of effective programs and policies with a focus on systemic change.
Statewide + Systemwide Initiative

Person-Centered Practices (PCP) assist individuals in having control over the life they desire, and fully engaging in their communities.

North Dakota is developing a strong and consistent statewide vision and universal understanding of person-centeredness across all North Dakota Department of Human Services entities and community partners.
How to Implement

- Bring diverse voices to the table
- Support individuals participating in services and statewide system change efforts
- Transform policies to reflect statewide person-centered values and culture
- Ensure communication is accessible and relatable
Support from Subject Matter Experts

Technical Assistance
The National Center on Advancing Person-Centered Practices and Systems (NCAPPS) helps states, tribes, and territories implement person-centered thinking, planning, and practice in line with US Department of Health and Human Services policy. North Dakota is one of 15 states to receive Technical Assistance for up to 100 hours of subject matter expertise for three years, to help advance person-centered thinking, planning, and practice. The third year begins in October 2020.

Collaboration with Local ND Stakeholders and Tribal Nations
Local organizations, advocacy groups, and representatives from Tribal Nations have contributed to development of North Dakota’s Person-Centered Practices initiative.

Project Management
Support for the statewide initiative, including coordination of efforts, is being provided by the Human Services Research Institute (HSRI).
Materials

www.hsri.org/nd-pcp
A public website with updates on North Dakota’s PCP system change initiative.

Asset Map
A working tool to:
• document existing stakeholder engagement opportunities
• encourage systematic and strategic thinking about next steps
• save time and resources
• reference when brainstorming potential groups to engage
• expand and improve on current systems and processes

Technical Assistance Plan
NCAPPS, HSRI, a cross-division workgroup and subject-matter experts are managing North Dakota’s plan and related activities to ensure system change.

Person-Centered Practices Summit
Three-part webinar series in Fall 2020 to engage individuals receiving services, their families, stakeholders, and providers in a true form of collaboration to reach a shared understanding of PCP, facilitate connections, embrace cultures and promote improvement for system change.

How to Engage Individuals Who Receive Services
North Dakota’s Guide of Best Practices outlines proven strategies on how to consistently involve individuals in workgroups and teams, so they are at the table when decisions are being made.
Person-Centered Practices Self-Assessment

All divisions in the Department of Human Services will engage in the Person-Centered Practices Self-Assessment process.

- Aging Services
- Developmental Disabilities
- Children & Family Services
- Behavioral Health
- Vocational Rehabilitation
- Administration Services
- Medical Services (Medicaid Office)
- Field Services (Life Skills & Transition Center)

The Self-Assessment is an online, internal tool for people who manage programs that offer support services to measure their progress toward building a more person-centered system.
## Areas Covered in Self-Assessment

<table>
<thead>
<tr>
<th>Leadership</th>
<th>Person-Centered Culture</th>
<th>Eligibility &amp; Service Access</th>
<th>Financing</th>
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<tbody>
<tr>
<td>How well people in charge know about and support person-centered practices.</td>
<td>How person-centered is the system’s culture and how can person-centered approaches help address risks.</td>
<td>How person-centered is the intake and assessment process for people seeking supports.</td>
<td>How are agreements with providers structured and how well are services helping people reach their goals.</td>
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<td>Person-Centered Service Planning</td>
<td>How is the process for creating person-centered plans and ensuring the services are working.</td>
<td>Workforce Capacity &amp; Capability</td>
<td>Collaboration &amp; Partnership</td>
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<td>How well staff know about and have the skills to deliver person-centered planning and supports.</td>
<td>How are partnerships with service users, families, service providers, and advocacy organizations.</td>
<td>The agency’s mission and standards.</td>
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Self-Assessment Process

1. Assign Division Leads and Determine Participants
2. Participants Take Online Self-Assessment
3. Review Scores and Establish Consensus on Baseline Status
4. Engage Stakeholders and Service Users to Inform Action Plan
5. Use Information to Create Action Plan
6. Communicate Action Plan Throughout the Division
7. Evaluate Progress Every Six Months
8. Update System Goals
### Status Update

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<th>Division</th>
<th>Task</th>
<th>Phase 1</th>
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Recap of First Webinar

Building Foundations for Person-Centered Practices

*Michael Smull*

- Person-Centered Planning is never done to you, is always done with you, and helps you move in a positive direction.
- Person-Centered Planning is about asking the right questions, respectfully listening, and organizing the learning.
- Good plans are living plans:
  - You feel that you have met the person (and not just the disability)
  - The plan respectfully reflects the person’s culture and identity
  - You know what the person wants the plan to accomplish
  - How to best support the person in moving toward their outcome(s) is clear
Tammy’s One Page Description

What is Important to Tammy (pages 7-8)
- Being a part of things
- Having eye contact with everyone
- Looking stylish and having her hair and nails done
- Being comfortable and not having her tubes underneath her
- No roughness in personal care

What People Like and Admire about Tammy (page 6)
- Is always smiling
- Totally accepts people
- WONDERFUL personality
- Stylish
- Accepting and forgiving
- Resilient
- Great sense of humor
- Friendly and social

Tammy’s Picture Of A Life (Pages 19-21)
- Live in a big wheelchair accessible home with extra wide doors, close to her family
- Have a fun and social housemate
- Have a beautician she can go to regularly
- Have a social medical day program close to home
- Have specialized medical services and medical equipment (including backup generator)

Supports Tammy Needs to be Happy, Healthy and Safe (pages 10-14)
- Always have her head elevated
- To be suctioned frequently (5-6 times per shift). Gurgling noises means she needs to be suctioned
- To have people be kind, sensitive, loving and have a gentle touch
- Be gentle with brushing her hair (she doesn’t like it, but wants it to always look nice)
- Always make sure her clothes match and make sure it’s not sweat clothes
- Tammy needs to be repositioned every two hours
- Always follow through with a promise or give an explanation of what is going on and when you can keep the promise if something comes up
- Be sure to have Tammy use her body to keep flexible
Describe what Person-Centered Practices are.
Presentation

Jennifer Turner, LCSW
Strategizer of Solutions, Charting the LifeCourse Nexus
turnerje@umkc.edu | 816-235-5450 | www.lifecoursetools.com

- Passionate about the development and implementation of best practice that will drive systems change and impact families.
- Lead for Organizational and System Change Initiatives at the University of Missouri – Kansas City, Institute for Human Development
- Her commitment to advocacy and social justice originates in her first – and most important – role of “big sister” to two siblings – a sister in her 30’s with a disability and a sister who is 15 and adopted.
- Licensed as a Clinical Social Worker
- Formerly a Support Coordinator and Director of a Provider Agency
- Co-Director for the National Community of Practice for Supporting Families
- Subject Matter Expert for the National Center on Advancing Person-Centered Practices and Systems
Today’s Objectives

1. Introduce the Charting the LifeCourse framework that is being used to enhance policy and practices around the country.

2. Toward the end Share concrete examples of the Person-Centered Practices that support choice, control, and decision-making.
Overview of the Charting the LifeCourse Framework
Who We Are

University of Kansas City Institute for Human Development, UCEDD conducts and collaborates on a wide variety of applied research projects to develop, implement, and evaluate new ideas and promising practices that support healthy, inclusive communities.
Charting the LifeCourse

Exchange
- Access to Resources and Tools
- Training
- Technical Assistance

Build
- Innovate and Enhance
- Develop
- Research

Collaborate
- Network and Connect
- Share Learning
- Share Stories
The National Community of Practice for Supporting Families

Enhances and drives policy, practice, and system transformation to support the person within the context of their family and their community.

Collaboration Between:

NASDDDS
National Association of State Directors of Developmental Disability Services

UMKC Institute for Human Development
A University Center for Excellence in Developmental Disabilities
Core Belief:
All people and their families have the right to live, love, learn, work, play and pursue their life aspirations in their community.
Transforming Services and Supports

Everyone exists within the context of family and community

Person in relation to Traditional Disability Services

Integrated Services and Supports within context of person, family and community
What is Charting the LifeCourse

Created to help individuals and families of all abilities and all ages:

• develop a vision for a good life
• think about what they need to know and do
• identify how to find or develop supports
• discover what it takes to live the lives they want to live
What is Charting the LifeCourse

- **Guiding Framework**
  - Guides thinking and problem-solving

- **Practices**
  - Specific Area (action, policy, procedure) to enhance or change

- **Tools**
  - Educational Resources Planning & Problem-solving Worksheets

www.lifecoursetools.com
Supporting a Person to Identify a Vision for a Good Life
The future is not something we enter.
The future is something that we create.
And creating that future requires us to make choices and decisions that begin with a dream.

-Leonard L. Sweet
Vision of a “Good Life”

What is YOUR Vision for a “Good Life”?

What is NOT a Good Life?
### Trajectory Towards Good Life

**VISION**
- Family
- Friends
- TATTOOS
- Vacations
- Girlfriend
- Concerts
- WWE
- NASCAR
- Money
- Job/own business
- Fire Station
- Church
- Tiger Football
- Royals
- Good Food
- Pepsi
- Beer
- Active
- Healthy & Fit

**WHAT I DON’T WANT**
- Poverty/No Money
- Poor Health
- Diabetes
- Heart Disease
- Guardian
- Isolated/Segregated
- Institution/group home
- Treated Differently
Life Experiences = Life Domains

Chores and allowance

Scouts, 4H, faith groups

Playing sports or an instrument

Birthday parties with friends

Dating & Heartaches

Learning to say “no”

Summer jobs, babysitting

Making Mistakes

CtLC Life Experiences Booklet and Quick Guides
Life Experiences = Life Outcomes = Good Life

More Possibilities → Vision → Expectations → Experiences → Opportunities
How the Story Began: Sarah

How Others Described Sarah:

- Cerebral Palsy: “mobility issues”
- Moderate Intellectual Disability: “requires significant support”
- Chronic Hydrocephalus with multiple shunts: “medically fragile”
- Low vision/hearing: “can’t navigate independently”

Sarah’s Family’s View:
Shaping the Rest of the Story: Sarah

- PT/OT/Speech Therapy
- "Part of the family" responsibilities
- Church programs with others
- KS State School for the Blind
- Self-identifying symptoms

- BASE Program for High School
- Volunteering @ CARE
- Dating
- Mentoring program

- What We Want
  - Live independently
  - Get married and have kids
  - Work with animals or kids
  - Close relationships with friends and family

- What We DON’T Want
  - Reliant on others for medical care
  - Taken advantage of
  - Bored, low self-esteem
  - Others make all decisions choices for her

Inexperienced medical team who did not listen
Moving to a new city and starting over
Tools for Exploring and Planning
Past Life Experiences
- Chores; boy scouts; School inclusion/circle of friends;
- Birthday parties; Riding bike; Family vacations;
- Church youth group; Debit card;
- Football manager; Volunteering High School diploma

Future Life Experiences
- Volunteer at fire station; Workout regularly;
- Keep in touch with friends; Increase alone time;
- Go out with friends; Spend daytime hours out of the house;
- Explore microenterprise;

Life Experiences to Avoid
- Sitting at home watching TV all day;
- Rely on paid supports;
- Gain weight;
- Eat unhealthy foods or drink too much Pepsi (caffeine);

What I DON'T Want
- Poor health, heart disease, diabetes;
- Poverty/no money;
- Guardianship; institution/group home;
- Segregation/isolation; being lonely;
- Being treated differently;

VISION for a GOOD LIFE
- Family and friends Girlfriend
- Vacations Concerts; WWE; NASCAR
- Tattoos Money; job or my own business
- Volunteer at fire station Being Tiger football manager
- Church
- Healthy & fit
- Good food; Pepsi Basketball Royals baseball
- Staying active

What I WANT
- Chores; School inclusion/circle of friends;
- Birthday parties; Riding bike; Family vacations;
- Church youth group; Debit card;
- Football manager; Volunteering
- High School diploma

Special education low expectations;
- Para glued to Ben's side; Pressure to segregate; Medication side effects;
- Scoliosis; Seizures; Physical barriers;

Write current age here

Staying active

Go out with friends; Spend daytime hours out of the house; Explore microenterprise;
**STAY HEALTHY/ACTIVE**
- Walk outdoors when it's nice weather
- Avoid contact with anyone other than Mom or Dad (social distancing)
- Get a list of other exercise ideas from Matt and Adam (weights, push-ups etc.) - use ZOOM
- Clean up the driveway basketball goal
- Healthy but yummy food choices
- Good and frequent hand washing
- Purell
- Wipe down surfaces daily
- Cover coughs and sneezes
- Check temperature regularly

**DAILY LIFE/Routine**
- Somewhat consistent wake/sleep times
- Shower daily
- Help with housework/cooking etc.
- Daily "schedule" of things to do such as exercise, physical activity, get outdoors etc.

**STAY CONNECTED**
- Facetime Matt and other family
- Skype or Facetime Fire Dept shifts
- Make an encouraging video for ESFD
- Help Ben get on Facebook daily and "like" or comment on friends posts
- Online church services on Sundays
- Front yard 10ft apart meet up with Steve

**STAY BUSY/NOT BORRED**
- iPad (WWE, music)
- Remote control truck
- "see stay connected"
- Golf in basement
- Family movie time
- Explore e-books

**POSSIBLE OBSTACLES/BARRIERS**
- Dad still has to work - potential exposure
- CO-VID on the news and other media all the time
- Other people not complying with social distancing
- CABIN FEVER IS REAL
- Grumpy weather/can't get outside

**WHAT WE WANT FOR BEN DURING THE CO-VID 19 CRISIS**
- Keep busy
- Keep working on fitness while he isn't able to access his trainer or the community center
- Stay Connected with:
  - Fire department friends
  - Valued staff
  - Family who don't live with us (especially Matt)
  - St Ann friends
  - Coffee friends & other community acquaintances
- Stay healthy and active
- Dad and Mom stay healthy too
- Keep a positive outlook on life - BE HAPPY

**WHAT I DON'T WANT**
- Boredom
- Get CO-VID19 or any other sickness
- Stress and worry
- Ben scared he will get sick
- Ben worried for parent's health
- Seizures or other diagnosis related health complications
- Sadness
- Missing family and friends
- Gaining weight/out of shape
Trajectory for Planning Meeting

Life Trajectory Worksheet

Past Life Experiences
- LIST past life experiences and events that supported your vision for a good life.
- Inclusion in Gen Ed Learning
- Education of support staff and students to provide understanding
- Exposure to various activities
- Riding the Reg Ed Bus
- Providing schedules and set expectations
- Help building friendships
- Educating my peers
- Letting me advocate for myself

Future Life Experiences
- LIST current/future life experiences that continue supporting your good life vision.

VISION for a GOOD LIFE

LIST what you want your "good life" to look like...

- Have a Job (Gainfully Employed)
- Make Friends (Have Quality Relationships)
- Make Money (Be Financially Independent)
- Have a Girlfriend (Find Love)
- Have Kids
- Live on My Own (Independently)
- Go Bowling (Participate in Community)
- Build things in the forest next to New York City (Have hobbies he enjoys)

What I DON'T WANT

LIST the things you don't want in your life...

- No Friends (Unhealthy Relationships)
- Get fired (Unstable Employment)
- No Girlfriend (Isolation)
- No Kids
- Stigmatized
Determining Who Will Help to Reach the Vision and How
CtLC
Integrated Support Star

PERSONAL STRENGTHS & ASSETS
Strengths:
Things a person is good at, or others admire or like
Assets:
Resources that are owned or can be accessed by the person
Skills:
Personal abilities, knowledge or experience

TECHNOLOGY
Personal Technology:
Common technologies used by anyone
Environmental Technology:
Innovative technologies designed to help a person navigate or adapt their surroundings
Assistive Technology:
Low-tech or specialized devices that assist a person with day-to-day tasks

RELATIONSHIPS
Family:
People that love, and are committed to each other
Friends:
People that enjoy being together, have things in common, and care about each other
Acquaintances:
People that come into frequent contact with the person but don't know them well

COMMUNITY RESOURCES
Places:
Businesses, faith communities, parks and recreation, health care facilities
Groups:
Civic and membership organizations
Government Resources:
Local services, i.e.: public safety, legal, social programs

ELIGIBILITY-SPECIFIC SUPPORTS
Disability Specific:
Supports received based on a diagnosis, i.e.: Special Education, Government Funded Disability Supports
Needs-based:
Supports based on age, gender, geographics, income level or employment status

Developed by the UMKC Institute for Human Development, UCEDD, July 2016
Integrated Services and Supports

**RELATIONSHIPS**

**Family:**
People that love, care about, and are committed to each other

**Friends:**
People that enjoy spending time together, have things in common, and care about each other

**Acquaintances:**
People that come into frequent contact with the person but don’t know them well.
Integrated Services and Supports

**PERSONAL STRENGTHS & ASSETS**

**Strengths:**
Things a person is good at or others admire or like

**Assets:**
Resources that are owned or can be accessed by the person

**Skills:**
Personal abilities, knowledge or experience
Integrated Services and Supports

**TECHNOLOGY**

**Personal Technology:**
Common technologies used by anyone

**Environmental Technology:**
Innovative technologies designed to help a person navigate or adapt their environment

**Assistive Technology:**
Low-tech or specialized devices that assist a person with day-to-day tasks
Integrated Services and Supports

COMMUNITY RESOURCES

Places:
- Businesses, faith communities, parks and recreation, health care facilities

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Integrated Services and Supports

ELIGIBILITY SPECIFIC SUPPORTS

Disability Specific:
Supports received based on a diagnosis, ie: Special Education, Government Funded Disability Supports

Needs-based:
Supports based on age, gender, geographics, income level or employment status
Focusing ONLY on Eligibility Supports

**Eligibility Supports**

- Friends, family, enough money, job I like, home, faith, vacations, health, choice, freedom
- Poverty, loneliness, segregation, restrictions, lack of choice, boredom, institutions

**Community**
- Family
- Services
- Person
Relying ONLY on Family and Friends

- Friends, family, enough money, job I like, home, faith, vacations, health, choice, freedom
- Poverty, loneliness, segregation, restrictions, lack of choice, boredom, institutions
Integrated Services and Supports

Friends, family, enough money, job I like, home, faith, vacations, health, choice, freedom

Poverty, loneliness, segregation, restrictions, lack of choice, boredom, institutions
CtLC
Integrated Support Star Tools + Resources
Mapping Relationships

Happy, Funny and loving
Likes to help people
Likes to try new things
Police cars, tow trucks, fire engines and racecars
Golf Cart

See his girlfriend more
Connect with his family
Spend more time with friends

Scouts
Red Robin
Race Tracks

I-pad
Smart Phone

Companion
Supports day-to-day

Eric's Social and Spiritual

Charting the LifeCourse  www.lifecoursetools.com
Problem Solving Transportation

- **Personal Strengths & Assets**
  - Ability to follow a bus route
  - Ability to input information in the Metro Trip Planner

- **Technology**
  - GPS
  - Find a Friend App
  - Google Maps
  - Metro Trip Planner

- **Relationships**
  - Neighbors
  - Co-Workers
  - Friends from Church
  - Family
  - Friends from Softball league

- **Community Based**
  - Ridefinders
  - Carpool Connections
  - Share the Ride STL
  - Uber

- **Eligibility Specific**

---

Charting the LifeCourse  www.lifecoursetools.com
Problem Solving for Decision Making Supports
Integrated Supports for Decision Making

• Supports a person needs to **understand their choices**:  
  • Information  
  • Advice

• Supports a person needs to **communicate their preferences**:  
  • Communication

• Supports a person needs to **follow through on their decisions**:  
  • Reminders and logistics
Break:
Five Minutes
Panelists Sharing Lived Experiences

Alisha Owens
Community Options Client

Lindsay Schuh
Community Options

Shannon Strating
Aging Services HCBS Program Administrator

Shannon VandeVenter
Parent
**PERSON AS LEGAL DECISION MAKER**
Makes their own decisions with no extra help from anyone else

**SUPPORTED DECISION MAKING**
Person makes their own decisions with support from others they know and trust

**GENERAL POWER OF ATTORNEY**
Person gives authority to another to act on their behalf in specific or all matters

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE**
Authorizes another to make health care decisions when the person cannot

**CONSERVATOR**
Court appoints someone to have the care and custody of the estate

**GUARDIANSHIP**
Court appoints guardian to have care and custody of the person
Exploring Supported Decision-Making Tool

**CHARTING the LifeCourse**

**Tool for Exploring Decision Making Supports**

This tool was designed to assist individuals and supporters with exploring decision-making support needs for each life domain.

**Name of Individual:**

**Name of person completing this form:** [Self, Family, Friend, Guardian, Other]

**How long have you known the individual?**

For each question below, mark the level of support you need when making and communicating decisions and choices in the Charting the LifeCourse life domains.

**DAILY LIFE & EMPLOYMENT**

- Can I decide or choose what I want to wear?
- Can I take a break if I need a job (hands-on, apply, sit personal context)?
- Do I plan my day when I will look best?
- Do I decide if I want to learn something new and how to best go about that?
- Can I make big decisions about money (pay bank account, make big purchases)?
- Do I make everyday purchases (food, personal items, recreation)?
- Do I pay my bills on time (over, under, electronic payment)?
- Do I keep a budget to know how much money I have to spend?
- Am I able to manage the obligations of my budget?
- Do I make sure no one is taking my money or using it for themselves?

**HEALTHY LIVING**

- Do I choose when to go to the doctor or dentist?
- Do I decide what doctors, medical/health clinics, hospitals, specialists or other health care providers I see?
- Can I make health/medical choices for my day-to-day well-being (medication, routine screening, workout and exercise)?
- Can I make medical choices in serious situations (surgery, my health)?
- Can I make medical choices in an emergency?
- Can I take medications as directed or follow a prescribed diet?
- Do I know the reasons why I take my medication?
- Do I understand the consequences of refusing medical treatments?
- Can I discuss other and seek medical help for serious health problems?
- Do I decide about birth control or pregnancy?
- Do I decide choices about drugs or alcohol?
- Do I understand health consequences associated with choosing high-risk behaviors (substance abuse, swimming, high-risk sexual activities, etc.)?
- Do I decide what, when, and how to eat?
- Do I understand the need for personal hygiene and dental care?

**SOCIAL & SPIRITUALITY**

- Do I choose where and when (and if) I want to practice my faith?
- Do I make decisions about what to do and who to spend time with?
- Do I decide if I want to date, and choose who I want to date?
- Can I make decisions about marriage (if I want to marry, and why)?
- Can I make decisions about my, and my disclosed spiritual beliefs and values?

**SAFETY & SECURITY**

- Do I make choices that help me avoid common environmental dangers (traffic, sharp objects, Age-stereotypes, animal products, etc.)?
- Do I make plans for emergencies?
- Do I know and understand my rights?
- Do I recognize and get help if I am being treated badly (physically, emotionally, sexually, abuse, neglect, pet)?
- Do I show who I communicate with if I feel safe or in danger, being exploited, or being treated unfairly (family, friends, friend, etc.)?

**COMMUNITY LIVING**

- Do I decide where (and who) I live with?
- Do I make sure choices around my home (turning off lights, keeping the doors, locking doors)?
- Do I decide about how I keep my home or room clean and healthy?
- Do I make choices about going places (how to get to work, bank, trips, church, friends, home)?
- Do I make choices about going places (I don’t have to go to others for appointments, special events)?
- Do I decide how often I wear (or need to go) (social, family, personal)?
- Do I decide and direct what kind of support I need and where and who provides those supports?

**CITIZENSHIP & ADVOCACY**

- Do I decide who I want to represent me and support me?
- Do I choose whether to stop and who votes for me?
- Do I understand the consequences of making decisions that will result in not being able to vote?
- Do I tell people what I want to talk about (by sign, written, and tell people how I decide choices)?
- Do I agree to avoid sign contracts and other formal agreements, such as powers of attorney?
- Do I decide who I want information shared with (family, friends, etc.)?

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Panelists

What are strategies for ensuring the person is informed of all their options – including the various supports and services – and is supported (as they need) to have choice and control?
Elevating the Voice of All Team Members

Supporting Person’s Self-Determination & Self-Advocacy

Supporting Families Across the Lifespan

Supporting Person-Centered Practices
Tools for All Team Members
Planning for Life Outcomes and/or Service Planning

Self-Advocate Tools & Resources

Family Perspective Tools

Formal Planning Tools & Forms
Family Perspective Tools

www.lifecoursetools.com/lifecourse-library/foundational-tools/family-perspective/
Panelists

What are strategies for ensuring the person has a voice in their planning process – and that it is distinct from the rest of the team?
Dignity of Risk and Mistakes

Never be defined by your past. It was just a lesson, not a life sentence.

Friends, family, enough money, job I like, home, faith, vacations, health, choice, freedom

Poverty, loneliness, segregation, restrictions, lack of choice, boredom
When a “risk” is identified, what are strategies to support the person and the team in planning for that risk?
Questions + Answers
Closing + Next Steps

1 Register for our next webinar (and invite colleagues and friends!) at: https://zoom.us/webinar/register/WN_Gt6Bb7B5QjWj_UstGlluZQ

2 Responses to the word cloud exercise will be used to develop a North Dakota definition of Person-Centered Practices.

3 View Charting the LifeCourse Resources at: www.lifecoursetools.com

4 Visit www.hsri.org/nd-pcp to view and use the materials currently available. The recording and slides from today’s webinar will be available within two weeks.

5 Complete the polling questions to help inform future webinars.
Thank You