Attachment C

Guidance Manual

In-Reach /Transitions to Community Living Tool

There are many manuals already available on how to facilitate Person-Centered Plans. This guidance document was prepared not to duplicate information already available, but rather to improve the quality of person-centered plans that are being conducted for individuals included in the Transitions to Community Living initiative in North Carolina. This guidance document is for both people who know little about Person-Centered Planning, and for those who have been using the methods and ideas for a long time.

The Transitions to Community Living plan is intended to be a Person Centered process. It should be completed over the course of several conversations or meetings with an individual and people that know the person best keeping in mind that being person centered is a process not a form. However, this format will help capture person centered information. Person Centered planning also involves gathering written information including assessments and other important documentation regarding person's services, health care, safety and other assessments that may have been completed. Person Centered Planning will typically not occur in a linear conversation or at one meeting. It is an ongoing discussion with an individual and others involved in the person's life including paid and natural supports. The following pages include instructions to help you understand the categories of the plan format. However, before completing this plan format it is important that you have Person Centered Thinking training.

A few important things to remember about the format: It is designed to be completed on the computer in the Microsoft Word. Each box in the format is expandable as information is filled in. If you choose to complete the form by hand, you can expand the boxes and print a template. If information is non-applicable in a category, please indicate N/A. Do not remove sections of the plan. The plan is written from the perspective of the person.

Section A

Demographics

In this section we are gathering basic demographics so that throughout the process this information is not asked by multiple people. Throughout the process this information will need to be updated as information changes. In Section A. 3, an Emergency Contact should be listed. This would be a person or persons that you would like to be contacted in the event of a medical and or mental health crisis. In Section A. 6., the name of the facility the client is currently residing in should be listed. However, if the person is not currently in a facility this should be indicated by N/A.

Section B

One Page Profile

A one-page profile typically has three sections: an appreciation about the person; what is important to that person from their perspective; what is important for the person, and how to support them well. This link will show you examples of profiles. This information is written in everyday not clinical language. Additional, information on how to develop one page profiles may be found at the following link **How To Develop One Page Profiles**.

Section C

Relationship Map

Identify the people the person likes in their life, this is based on information from the person and people who know the person well. The person's name is placed in the center of the map. Indicate who is closest to the person by moving from the inside to the outer circle. Look at any these sections that are blank or for patterns in relationship's. How close is the person's family? Does the person have contact with neighbors or local people? Do they have friends? Are there only paid supports included in the map? Does the individual want to reconnect with anyone that they have lost touch with?

Section D

How I Got To Where I am Today

Ask the individual about the past, significant events, family life, and work. For each category, indicate what the person has tried, what have they learned, what they are pleased about, and what caused them concern, if any, in each category.

Community Living- Where did you live before coming to the adult care home or state hospital? What is the name of the last Adult Care/Hospital that you lived in? How was the decision made for you to move to an adult care home/hospital? Were you involved in making the decision? What other places have you lived before? Have you lived alone before (counties, states)? Have you had roommates? How did you come to live in an adult care home? How long have you lived here? How long were you in the hospital? Where would you most like to live? What type of place would you like to live in? Is there a particular community, town, or county where you would like to live?

Employment/Volunteering/Day Activities- Where are some of the places that you have worked before? How long did you work there? What types of work are you most interested in? Have you or your family members ever served in the military? Have you ever considered/volunteered?

Learning – This section is about educational history as well as future interest in returning to school or taking classes. Where did you go to school? Do you have any interest in taking classes or going back to school? Did you graduate high school? Did you go to college?

Managing Money – This section is about identifying how someone approaches staying on top of their household bills. Do they have benefits such as SSI or SSDI? What is their current income? Are they eligible for other benefits such as low income energy assistance or food stamps? How do they keep track of their personal budget? Do they have assistance with managing money? Do they have a payee? Do they have a bank account? Do you need assistance with paying household bills and other money management?

Family /Relationships – Include the closest relationships from the Relationship Map. Inquire about past relationships that the individual may have an interest in reconnecting. Do not include individuals that the person does not want you to include. Remember this process is person centered. If someone chooses not to share information, this should be respected. Ask if family members would like any information about caregiver support options? Is there anything specific you would like me to know about your family involvement?

Living Safely/Taking Risks – This section will identify strategies for safety during a transition from facility to the community. This section also involves asking about prior criminal charges or legal involvement. This section also involves identifying risks and supports needed to eliminate or minimize risk. Will the person have sufficient medication upon moving out, etc.?

Also consider fire safety skills such as knowing when to get out during a fire, who to call, use of extinguishers. Also, consider community safety skills such as keeping the door locked, using a peep hole, a buddy system, cell phone for emergency use.

Health and Well Being – This section describes getting the right medical treatment. Do they need OT, PT, PT, and Counseling? Also consider exercise, eating well, and identify what helps the person feel good about themselves and their life. This may also include durable medical equipment such as aids and adaptive equipment needed to assist the individual to do things independently. Does the person require a wheelchair, walker, or braces? Are home modifications required such as widened doorways, bathroom handrails, and ramps? Are home monitoring devices needed such as a life line, etc.?

Everyday Living Skills – This includes practical tasks around the house like cooking, cleaning, and other skills required to maintain a home. Use of appliances and household items should be considered. Do you need assistance with meal preparation? Can you use a stove or microwave? This may also include assistance with understanding tenant/landlord rights and responsibilities as well as assistance talking with or negotiating with landlords. Do you know where the local post office is? Can you access your bank account when you need to? Do you have a driver's license, state ID, social security card? Do you have a safe place to keep important papers?

Leisure – Inquire about how the individual likes to spend time when they are alone and with others. Inquire about favorite activities such as TV, movies, sports, cooking, crafts, and social events.

Medical Care – Identify current medical issues and conditions. Ask what the perception of the severity of the condition is.

Behavioral Health Care – Identify mental health support needs. Identify any substance abuse support needs. Does the individual have a community based psychologist, psychiatrist, counselor. What type of community based mental health and or substance abuse services does the individual currently receive?

Personal Care –The intent of this section is to identify when someone needs assistance with their personal hygiene such as bathing, using the bathroom, dressing, shaving, etc. This also includes taking medications/remembering to take medications. This includes care that would require someone to come into to provide such as a CNA including mobility and assistance with feeding. If someone typically manages to take care of their own personal needs on their own, then a brief explanation is all that is required.

Transportation – Do you have and know how to use public transportation? Can you get to appointments? Can you go to the store, to medical appointments, bank?

Community Services/Other - Are there other available community resources that would assist the person in living the life that they choose. Would you like to be connected to a Peer Support? Are there social opportunities in the community that you would like to participate in? Would you like assistance in finding opportunities and resources? Do you have a plan for helping build supports in the community? Would you like assistance with this? Do you have a plan if your family or other natural supports can't help you?

Section E

My Perspective

This section includes the person's perspective regarding what is working, not working, and how they would like to change in the life areas. This information is gained from information that the person shares with you. If the individual does not use words to communicate, then information from an individual that is closet to the person and who can convey information on behalf of the person and in their best interest. What is working includes those things that are going well, what the person wants to keep in their life, things that they enjoy and are helpful to them. What is not working may include things that are not going well for the person, issues or concerns that need resolving, etc. How you would like this to change includes: what would make this better? How can this be fixed? Is there something or someone that can help with this?

Section F

Other's Perspective

This section should include the perspective of anyone who supports the individual who wants to be a part of the planning process. This may include but not be limited to family, friends, service providers, care coordinators, In Reach Workers, Transition Coordinators, and Adult Care Home staff. This page

includes the same life areas including in the "My Perspective" section.   This page can be duplicated as many times as is necessary to capture the perspective of others involved in the support of an individual. Other perspectives may vary widely from the individual's perspective. This is an important part of the person centered process. It is important to capture the perspectives of others. It is often the case when something doesn't make sense to the person that it makes sense to others and vice versa. It is important to discuss these matters and take them into consideration when planning with an individual. This help to analyze an issue/situation across multiple perspectives. It also provides a picture of what people feel is working/not working at the present time.

Section G

Assistance Through the Process

This section provides insight into areas that the person may need assistance with during and after the transition process. In this area, please document the person's perspective as well as the perspective of staff regarding any assistance needed. Indicate specifics around the assistance that may be needed. If there is a difference in perspective between the person and others including staff then a discussion should be held to ascertain the areas of agreement and/or disagreement. If needed, education regarding potential consequences or plans for additional support should be discussed. For example, if the person is insulin dependent and does not feel they need support in place initially but it is later determined that assistance is required to prevent medical complications.

Section H

A Good Week of Meaningful Days

Meaningful Days – Include how the person would like to spend their days. This includes what the person would be doing on the different days of the week. This may include information such as social activities, everyday living tasks, shopping, work or volunteering. . This should include how a typical week would look for the individual. This might include any recovery services and support groups. This might include other clubs or social functions. This may also include leisure and fun activities. This may include church services and bible studies as well as cultural events.

Section I

Medical and Behavioral Health Information

In this section please list all the physicians that are working with the person and ensure that you have all contact information as well as why the person is seeing each doctor. Please provide information on the person's medical and mental health conditions as well as pharmacy information. Also, provide specific information around the medications the person is taking as well as medications they do not want to take in the future. In this section also list medications that the person is taking as well as the pharmacies where they receive their medications.

Section J

What You Need to Know to Support Me in a Crisis

This section should serve as a detailed but concise Crisis Plan. This section should identify what is happening around the person during a crisis, the person's actions and what they mean during a crisis and what should happened to address the crisis. This section asks four questions: What is happening? This is what I do? This is what it means? This is what you should do? "What is happening" should include known triggers for crisis and potential triggers for crisis. "This is what I do" should describe the person's behavior and what they say and do during a crisis. This section identifies what an individual does during the crisis. "This is what it means" should include what the person tells us that it means as well as what we think it means. "This is what you should do" informs us what action should be taken as well as who should take action to address the crisis.

Section K

Other Important Information to Know About Me

This is information that a person may not have felt that was covered in the categories reflected in this plan format. This can include any additional information that the individual chooses to share.

Section L

Improvements I Would Like to See In My Plan

This section might include comments by the individual indicating agreement or disagreement with information contained in the plan. For example, a person may have a diagnosis of Major Depression documented on a Comprehensive Clinical Assessment. However, the individual may feel like they are doing so well that they don't have depression anymore. So they may indicate in this section that they disagree with a formal diagnosis and would like that to change.

Section M

Signatures

This section should include the signature of the person, guardian (if applicable), the In-Reach Specialist and Transition Coordinator. Other members of the person's team and support network may sign the plan as well. All signatures should include the relationship to the person and the date.

This section should also include signatures when the plan is updated. Plans should be updated when substantial information changes. Plans should be revised by adding additional information in the body of the plan. Each box expands to allow for additional information. The date (mm/dd/year) should be

included beside the updated entry. The plan should then be signed by the individual and the person revising the plan. The date of the revision should be included on the signature page.