9 Elements of a Person-Centered System: Outcomes

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The NCAPPS Five Competency Domains for Person-Centered Planning describe five skill areas, or domains, that facilitators should possess to support a fully person-centered planning process. The domains were developed in 2022 based on two decades of experimentation and improvement in effective person-centered planning. These domains call on facilitators to learn about the kind of life a person wants and determine the support needed to make it possible. What needs to change and what must stay the same for the person to move toward or sustain their desired life? Efforts to deal with issues of health or safety ("what is important for") are described in the context of the person having what matters to them ("what is important to").

Effective ways to learn the outcomes each individual wants have been developed and used since the 1980s. NCAPPS has synthesized some of this learning in the Five Domains. The challenge is not finding a set of skills that help us describe how each person wants to live; the challenge is doing it well for everyone. We want to do good and effective person-centered planning for every person, not just the exceptional few. Doing this at scale has been, and remains, the challenge. Techniques and skills have been developed that allow us to have excellent descriptions of what needs to stay the same and what needs to change for people to move towards their desired life. The nature and severity of the disability only matters in that there may be

Person-Centered Planning Competency Domains

A. Strengths-Based, Culturally Informed, Whole Person-Focused

B. Cultivating Connections Inside the System and Out

C. Rights, Choice, and Control

D. Partnership, Teamwork, Communication, and Facilitation

E. Documentation, Implementation, and Quality Monitoring

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a specific skill or technique that needs to be learned and used to have a good plan. Good plans also require that the person facilitating them have not only the competencies, but the time and the resources needed. Those who are developing the plans need to see them being used and making a difference. Good plans describe the outcomes the person wants to reach. The outcome captures the desires of what the person wants to achieve and is not service based. For example: To participate in physical therapy three times a week to regain and sustain mobility may be a goal, while the outcome is riding in the MS 150 Bike Challenge in April 2024. The outcome is the ultimate desired achievement or state. Goals help a person move toward that state.

Where people need support from the system, the support required, and preferences for how it is delivered should be part of the plan.

Time available and system capacity are significant barriers. Developing a good plan requires that we listen to the person and those around the person, those who know and care about the person. This takes time and skill. Good plans are done in partnership. The quality and accuracy of the content in a plan is dependent on the strength of relationships and depth of knowledge of the person. Content should come from the person and those who know the person best.

The process of developing the plan requires that people in plan development roles know how a plan is constructed; how a plan is going to be used in the delivery of services and supports; how to gather and present information that makes the plan effective and usable to people in support roles; and how to create outcomes that truly reflect a balance between "important to" and "important for." In a sense, good plan developers use the information to paint a picture of what a balanced life will look like from the person's perspective.

Developing a good plan is, in a significant way, making a set of promises to the person. A core promise is that we will act on what we have learned. Where meeting the desired outcomes requires a change in setting, that change must be possible. Where system capacity is not effectively used or does not currently exist, and we do not act to use or build the capacity, we are breaking the promise. This is not only traumatic for the person to whom we have made the promises to but also for those who have developed the plans and made the promises. What is funded must align with what is needed. The rules and regulations must align with acting on the desired outcomes.

Individual plans are more likely to be implemented where there is a champion. This is someone who not only has the skills but is personally invested in seeing the person get what is promised in the plan. This is another challenge of scale. When individuals are expected to plan with multiple people, or the development of a plan is just one of multiple responsibilities, there are rarely champions for every individual with whom we plan.

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Plans reflect learning, and that learning only matters if it is used. Plans should not be viewed as an annual event, but rather based on the significant learning that happens day to day. Planning should be an iterative process. The learning for the current plan builds on the learning of the previous year. Plans should build on each other. What is learned from implementation in the first year is used to frame the development of the plan in the second year, and then the third-year builds on the second year, and so on. In teaching this, we say a "first plan" should only be done once.

Part of the iterative process is recognition that what people have tried has significant impact on what they want. We all benefit from trying new things, having new opportunities. Learning from opportunities tried over the past year are the basis of what new opportunities should be offered.

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Another critical function of the plan facilitator is to listen for identity. They need to support the person to explore aspects of culture and identity that are important to them, and to ensure those are reflected in the plan. The challenge is to not let the bias of the facilitator, or the contributors mask the issues that the person would like to have addressed. In this work, cultural competence is needed, and cultural humility is required. Cultural competence means that the facilitator honors and respects the person's beliefs, values, interpersonal communication style, and behaviors; and tailors the planning process to meet the person's unique social, cultural, and linguistic needs.[1] Cultural humility is a

[1] Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches, Joseph R. Betancourt, M.D., M.P.H., Alexander R. Green, M.D., and J. Emilio Carrillo, M.D., The Commonwealth Fund, October 2002

lifelong process of self-reflection and critique where the facilitator not only learns about other cultures but examines their own beliefs and cultural identities.[2]

The planning process should support choice and control. The person should have as much control over the process as is feasible and desired by the person. Person-centered work helps connect people to their communities and build relationships that are reciprocal. The desired outcome for everyone is to support them on a journey to a life with purpose and meaning within communities of their choosing.

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[2] Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor and Undeserved, 9, 117-125.