NCAPPS OVERVIEW
The goal of NCAPPS is to promote systems change that makes person-centered principles not just an aspiration but a reality in the lives of people across the lifespan.
What is person-centered thinking, planning, and practice?

**Person-centered thinking**
- A foundational principle requiring consistency in language, values, and actions
- The person and their loved ones are experts in their own lives
- Equal emphasis on quality of life, well-being, and informed choice

**Person-centered planning**
- A methodology that identifies and addresses the preferences and interests for a desired life and the supports (paid and unpaid) to achieve it
- Directed by the person, supported by others selected by the person

**Person-centered practices**
- Alignment of services and systems to ensure the person has access to the full benefits of community living
- Service delivery that facilitates the achievement of the person’s desired outcomes
NCAPPS Leadership Team

Administration for Community Living (ACL):
• Shawn Terrell
• Serena Lowe
• Thom Campbell
• Dana Fink
• Joseph Lugo

Centers for Medicare & Medicaid Services (CMS)
• Amanda Hill
• Melissa Harris

Human Services Research Institute (HSRI):
• Co-Directors - Alixe Bonardi and Bevin Croft
• PAL-Group Coordinator – Nicole LeBlanc
• Project Coordinator – Miso Kwak
• TA Leads - Yoshi Kardell, Jami Petner-Arrey, Teresita Camacho-Gonsalves, Alena Vasquez
National Organization Partners

- National Association of State Head Injury Administrators (NASHIA)
- National Association of States United for Aging and Disabilities (NASUAD)
- National Association of State Directors of Developmental Disabilities Services (NASDDDS)
- National Association of State Mental Health Program Directors (NASMHPD)
- National Association of County Behavioral Health and Developmental Disabilities Directors (NACBHDD)
- National Association of Medicaid Directors (NAMD)
Subject Matter Experts

• Georgetown National Center for Cultural Competence
• Support Development Associates
• University of Missouri Kansas City Institute for Human Development
• Independent Living Research Utilization and the National Center for Aging and Disability
• Mission Analytics
• Applied Self Direction

• Collective Insight
• Eden Alternative
• Pioneer Network
• Live & Learn, Inc.
• Joe Caldwell, PhD
• Suzanne Crisp
• Mark Friedman, PhD
• Janis Tondora, PsyD

...and others
Person-Centered Advisory and Leadership Group (PAL-Group)

- Majority are people with direct lived experience of navigating HCBS systems
- Membership built with a strong focus on diversity of perspectives, experiences, and backgrounds
- Promotes and actualizes participant engagement in all NCAPPS components and activities
- Meets twice a year, plus additional ad hoc meetings and communications
- As subject matter experts, members will contribute to webinars, resource development
To be person-centered means to function in a way that creates a culture where staff and providers presume competence, have high expectations and embrace the dignity of risk. Learning to “Let Go” is one thing we must strive for as a system. By doing this it will support people with disabilities to live the DREAM and experience life to the fullest.

Nicole LeBlanc – PAL-Group Coordinator
Our Website
ncapps.acl.gov
NCAPPS Webinars

- Delivered by national experts and people with lived experience
- Coordinated and hosted by HSRI
- Free and open to the public
- Topics derived from technical assistance and priorities identified by the PAL-Group
- All webinars recorded and archived on our website ncapps.acl.gov

July 2019 Webinar
Pieces of the Same Puzzle: The Role of Culture in Person-Centered Thinking, Planning, and Practice

August 2019 Webinar:
Considering Brain Injury: Why Being Brain Injury-Informed Is a Critical Component of Person-Centered Thinking, Planning, and Practice

September Webinar: Microboards 101: An Introduction to a Person-Centered Solution Offering Full Accountability, Active Community Support, and Lifelong Continuity of Care
Monday, September 16th, 2:00pm to 3:30pm Eastern
To register, visit: https://zoom.us/webinar/register/WN_qXFYpdO4R3i_NgA6umB6_g
Learning Collaboratives

Goal: Promote peer-to-peer learning to accelerate improvement efforts

• Structured group work with support from subject matter experts
• 12-24 months duration, depending on topic and improvement framework
• Membership open to technical assistance recipients and other system stakeholders with expressed interest
Learning Collaborative Topics

• Person-Centered Thinking, Planning, and Practice for People with Brain Injury [FALL 2019]

• Beyond Compliance: Enhancing Person-Centered Thinking, Planning, and Practice in Alignment with the HCBS Final Rule [SPRING 2020]

• Tribal Adaptations to Person-Centered Thinking, Planning, and Practice [FALL 2020]

• In the Driver’s Seat: Realizing the Promise of Self-Direction [TBD]

• Amplifying the Voice of Lived Experience in Human Service Systems [TBD]
Goal: Support systems change efforts so the participant and family are at the center of thinking, planning, and practice

- Available to up to 15 States, Tribes, or Territories each year
- Up to 100 hours per year for three years
- Delivered by national experts based on a detailed technical assistance plan
Technical Assistance Expectations

With HSRI support, selected technical assistance recipients:

1. Develop **concrete goals and objectives** based on one or more technical assistance domains (practice, policy, payment, participant engagement)

2. Create an **evaluation plan** for collecting, analyzing, and reporting whether and how each technical assistance goal will be met

3. Establish **strategies for meaningful participant and family engagement** in the technical assistance process and all systems change efforts
## Selected States and Lead Agencies

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<tr>
<th>State</th>
<th>Lead Agency</th>
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<tbody>
<tr>
<td>Alabama</td>
<td>Alabama Department of Mental Health (DMH)</td>
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<td>Colorado</td>
<td>Colorado Department of Health Care Policy and Financing (HCPF)</td>
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<tr>
<td>Connecticut</td>
<td>Connecticut Department of Rehabilitation Services (DORS) State Unit on Aging</td>
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<td>Georgia</td>
<td>Georgia Department of Human Services (DHS) Division of Aging Services (DAS)</td>
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<td>Hawaii</td>
<td>Hawaii Department of Human Services (DHS) Med-QUEST Division</td>
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<td>Idaho</td>
<td>Idaho Department of Health and Welfare, Division of Medicaid</td>
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<td>Kentucky</td>
<td>Kentucky Department for Aging and Independent Living (DAIL)</td>
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<td>Montana</td>
<td>Montana Department of Public Health and Human Services (DPHHS) Senior and Long Term Care</td>
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<td>North Dakota</td>
<td>North Dakota Department of Human Services (DHS)</td>
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<td>Ohio</td>
<td>Ohio Department of Medicaid (ODM)</td>
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<td>Oregon</td>
<td>Oregon Department of Human Services (DHS) Aging and People with Disabilities (APD)</td>
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<td>Pennsylvania</td>
<td>Pennsylvania Department of Aging (DOA) Aging and Disability Resource Office</td>
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<td>Texas</td>
<td>Medicaid and CHIP/ Policy and Program Development/ Texas Health and Human Services</td>
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<tr>
<td>Utah</td>
<td>Utah Division of Services for People with Disabilities (DSPD)</td>
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<tr>
<td>Virginia</td>
<td>Virginia Department for Aging and Rehabilitative Services (DARS)</td>
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UTAH’S TA GOALS AND CURRENT OBJECTIVES
Goal 1: By March 31, 2020, DSPD will identify and test two specific strategies to support greater levels of self-advocate, service user, and family engagement.

1. Map existing engagement strategies already in place and their strengths and opportunities for improvement (e.g., existing vs. intended target groups, focus, frequency, accommodations, feedback loop). Identify and secure engagement with all relevant stakeholders, including service users and families.

2. Using the Asset Map, identify two new engagement strategies to test.
Goal 2: By September 30, 2019, DSPD will create a draft Communications Strategy that outlines a plan for increasing stakeholder buy-in and awareness of person-centered thinking, planning, and practice.

1. Draft a **Communications Strategy** for increasing stakeholder **buy-in and awareness of person-centered practice**. The Communications Strategy will detail regular and ongoing communications with service users and families and providers, identify multiple methods of communication, and strategies for measuring the effectiveness of the communications strategy so that it can be refined over time.
Goal 3: By September 30, 2020, ensure that person-centered thinking and planning are translated into practice through revised Person-Centered Support Planning standards and procedures.

1. Develop an **outline for a user manual** of the PCSP process.

2. Identify a suite of potential **person-centered planning tools** (including pre-planning tools) to be used in the PCSP process.

3. Create a **draft protocol** for integrating the use of those tools into the PCSP process and electronic health record.
Jenny Turner, LCSW

- Sibling of two sisters, one who is in her 30s with a disability
- Licensed as a Clinical Social Worker
- Formerly a Support Coordinator and Director of a Provider Agency
- Senior Research Associate, UMKC Institute for Human Development
What is a Community of Practice?

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

Build
- Innovate and Enhance
- Develop
- Research

Collaborate
- Network and Connect
- Share Learning
- Share Stories
Services and Supports are Evolving

- Everyone exists within the context of family and community
- Traditional Disability Services
- Integrated Services and Supports within context of person, family and community
1950s Mom---------Parent-----Family Movement

1970s Self-Advocacy and Independent Living Movements (Nothing about me, without me!)

2000s Siblings Movement

1960s Medicaid and Medicare Established

1980s Medicaid Waiver (Community Supports)

2010s Affordable Care Act

1970s Rehab Act: 504 Plans

1975s Education for All Children

1990s IDEA and ADA

2000's Community and Society

Joining Forces for a New Vision
Current Reality of Services and Supports

- Expectations, Values, Culture
- Demand for Services
- Federal Budget
- Capacity of Work Force
- Federal Policy
- Person
- Services
- Family
- Community
What is a Community of Practice?

The significant problems we face can not be solved at the same level of thinking we were at when we created them.

Albert Einstein
Type of Change that is Needed

**Transitional Change**
- “Retooling” the system and its practices to fit the new model
- Mergers, consolidations, reorganizations, revising systematic payment structures,
- Creating new services, processes, systems and products to replace the traditional one

**Transformation Change**
- Fundamental reordering of thinking, beliefs, culture, relationships, and behavior
- Turns assumptions inside out and disrupts familiar rituals and structures
- Rejects command and control relationships in favor of co-creative partnerships

*Creating Blue Space, Hanns Meissner, 2013*
What is a Community of Practice?

Goal of the National CoP

To build capacity, *through a community of practice*, across and within States to create policies, practices and systems to better assist and support families that include a member with an intellectual and developmental disability across the lifespan.

SUPPORTING FAMILIES of individuals with intellectual & developmental disabilities

*National Community of Practice funded by the Administration on Intellectual & Developmental Disabilities*
Evolution of CtLC Framework

2010
Missouri
UCEDD and
Mo Family to
Family

2011
National
Agenda on
Supporting
Families
(Wingspread)

2012
National
Community of
Practice
on Supporting
Families

Supporting Families
LifeCourse Principles

Charting the LifeCourse
Framework and Tools
Application of 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
Thinking That Guides the Framework

- LifeCourseTheory
- SocialCapital
- Person-CenteredPractices
- Socio-ecologicalModel
- Family-CenteredPractices
- CommunityIntegration
- PublicHealthModel
- AnticipatoryGuidance
- Self-Determination
Core Belief: All people and their families have the right to live, love, work, play and pursue their life aspirations in their community.
National “All People” with ID/DD

100%
4.7 Million people with developmental disabilities

75%

25%
National % Receiving State DD Services

** Based on national definition of developmental disability with a prevalence rate of 1.49%
Where do People with ID/DD Live?

4.7 million estimated People with Developmental Disabilities*

75%
3,500,000
Not Known to Services

12%
672,000
Living at Home

11%
528,000
Out of Home Services

What is a Community of Practice?

- Family is defined by the individual
- Individuals and their family may need supports that adjust as roles and needs of all members change
- Not dependent upon where the person lives
## Caring About

<table>
<thead>
<tr>
<th>Affection &amp; Self-Esteem</th>
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<tr>
<td>Repository of knowledge</td>
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<td>Lifetime commitment</td>
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## Caring For

<table>
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<tr>
<th>Provider of day-to-day care</th>
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<tr>
<td>Material/Financial</td>
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<tr>
<td>Facilitator of inclusion &amp; membership</td>
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<tr>
<td>Advocate for support</td>
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All People Exist Within the Context of Family and Community

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[UMKC Institute for Human Development](https://www.umkc.edu/ihd/)

*Charting the LifeCourse Nexus*
Good Life for ALL

**Individuals** will achieve self-determination, interdependence, productivity, integration, and inclusion in all facets of community life.

**Families** will be supported in ways that maximize their capacity, strengths, and unique abilities to best nurture, love, and support all individual members to achieve their goals.
What is a Community of Practice?

Vision of 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.

What I Want for Quality of Life
What is a Community of Practice?

Vision of a Good Life

Vision of What I Don’t Want
Trajectory Towards a Good Life

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

Vision of What I Don’t Want

Trajectory towards Life Outcomes

Trajectory towards things unwanted
Life Trajectory Worksheet

Past Life Experiences
LIST past life experiences and events that supported your vision for a good life.

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

Write current objectives

LIST past life experiences that moved you toward things you don't want.

LIST life experiences to avoid because they move you toward things you don't want.

VISION for a Good Life
LIST what you want your “good life” to look like...

What I Don’t Want
LIST the things you don’t want in your life...
Parents Turn 65
Medicare & SSDI

Parents
Turn 65
Medicare & SSDI

Getting New Diagnosis

Leaving Early Childhood/ enter school

Transition planning

Turning 18. Leaving school at 18 or 21

Making Mistakes

Summer jobs, babysitting

Playing sports or an instrument

Chores and allowance

Learning to say “no”

Birthday parties with friends

Scouts, 4H, faith groups

Leaving Early Childhood/ enter school

Transition planning

Turning 18. Leaving school at 18 or 21

Making Mistakes

Summer jobs, babysitting

Playing sports or an instrument

Chores and allowance

Learning to say “no”

Birthday parties with friends

Scouts, 4H, faith groups

My parents have passed away, what do I do?

Parents Turn 65 Medicare & SSDI

Leaving Adult Life

My parents have passed away, what do I do?

Parents Turn 65 Medicare & SSDI

Leaving Adult Life

Trajectory Towards a Good Life

Getting New Diagnosis

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Transition planning

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Scouts, 4H, faith groups
Anticipatory Guidance & Life Experiences
Integrated Life Domains

- **Daily Life and Employment**
  - School/education, employment, volunteering, routines, life skills

- **Community Living**
  - Housing, living options, home adaptations and modifications, community access, transportation

- **Social and Spirituality**
  - Friends, relationships, leisure activities, personal networks, faith community

- **Healthy Living**
  - Medical, behavioral, nutrition, wellness, affordable care

- **Safety and Security**
  - Emergencies, well-being, legal rights and issues, guardianship options and alternatives

- **Citizenship and Advocacy**
  - Valued roles, making choices, setting goals, responsibility, leadership, peer support
Integrated Life Domains

CHARTING the LifeCourse

Tool for Developing a Vision – Tracy’s

Forming a vision and beginning to plan for the future in each of the life domains helps plot a trajectory for a full, inclusive, quality life in the community. This tool is to help individuals with disabilities of all ages think about a specific vision in each life domain for how they want to live their adult life, and prioritize what they want to work on right now that will help move toward the life vision.

<table>
<thead>
<tr>
<th>LIFE DOMAINS</th>
<th>My Vision for My Future</th>
<th>too by</th>
<th>Current Situation/Things to Work On</th>
</tr>
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<tbody>
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<td>Daily Life</td>
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May 2014
Three Types of Support

Discovery & Navigation (Info and Training)

Connecting & Networking (Talking to someone that has been there)

Goods & Services (Day to Day, Medical, Financial Supports)
<table>
<thead>
<tr>
<th>Overarching Area (3 Buckets)</th>
<th>Focus Area of Enhancement</th>
<th>Examples of Services or Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discovery and Navigation</td>
<td>Informational Support</td>
<td>• Informational Support <em>(specific disability or health condition, options and possibilities for employment, community living, relationships, recreation, future planning)</em></td>
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<td>Instructional Skills</td>
<td>• Skill Building Support <em>(navigating and access services, behavioral supports, medical tasks)</em></td>
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<td>Development</td>
<td>• Interventions that enhance the ability to advocate for services and policy change</td>
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<td>Navigation and Advocacy</td>
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<tr>
<td>Connections and Networking</td>
<td>Emotional Support</td>
<td>• Support Groups</td>
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<td>Affirmational Support</td>
<td>• Professional Counseling</td>
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<td>Relationships and Social</td>
<td>• Peer-to-peer interventions and programs <em>(Parent-to-Parent, Sib-shops, Self-advocacy organizations)</em></td>
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<td>Capital</td>
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<tr>
<td>Goods and Services</td>
<td>Physical Support</td>
<td>• Individual and Family-Directed Supports</td>
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<td>Financial Material/</td>
<td>• Cash Subsidies and Financial assistance</td>
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<td>Instrumental</td>
<td>• Transportation</td>
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<td>• Respite/Childcare</td>
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<td>• Adaptive equipment and Home modifications</td>
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</tbody>
</table>
Integrated Services and Supports

More than “Natural Supports and Formal, paid developmental disability services and supports
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

INTEGRATED SUPPORTS

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, geographic, income level or employment status

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

PERSONAL STRENGTHS & ASSETS

TECHNOLOGY:

RELATIONSHIPS:
Mom, Dad

COMMUNITY BASED:

ELIGIBILITY SPECIFIC
DDD Self-Directed waiver PCA staff; Medicaid; Special Needs Trust

Ben’s Services & Supports

Long-Term Service and Support Needs

<table>
<thead>
<tr>
<th>Time</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
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</tbody>
</table>
AFTER: Services and Supports

PERSONAL STRENGTHS & ASSETS
- Able to stay home alone for up to an hour; has & can use i-pad;
- i-pad when home alone; digital watch
- Ben's Services & Supports

TECHNOLOGY:
- i-pad when home alone; digital watch

RELATIONSHIPS:
- Mom, Dad, Matt, Zac, Ali, Chad, Ericka, Roy, Carol, Nick, Spohn,

COMMUNITY BASED:
- Firemen at ESFD; coaches & staff at ES high school; Omni bus;

ELIGIBILITY SPECIFIC:
- DDD Self-Directed waiver PCA staff; Medicaid; Special Needs Trust

Mom, Dad, Matt, Zac, Ali, Chad, Ericka, Roy, Carol, Nick, Spohn, Firemen at ESFD; coaches & staff at ES high school; Omni bus; Medicaid; Special Needs Trust; DDD Self-Directed waiver PCA staff; Services & Supports
Ben’s Life Activities

**PERSONAL STRENGTHS & ASSETS**
- Can stay home alone for up to one hour

**TECHNOLOGY:**
- I-pad to watch WWE network and music videos; facebook

**RELATIONSHIPS:**
- Mom, Dad, Matt, Zac & Ali; firemen friends; Nick, Spohn, Mike, Ange, Chad, Ericka & twins

**COMMUNITY BASED:**
- Fire Station, Wal-Mart, movies, bowling, Sonic, Price Chopper, Church, High School, IHD

**ELIGIBILITY SPECIFIC**
- Paid staff thru SD waiver help with activities, ADL’s & access community; therapeutic riding

---

**CHARTING the life course**

**Integrated STAR Activities**

<table>
<thead>
<tr>
<th>TIME</th>
<th>MON</th>
<th>TUES</th>
<th>WED</th>
<th>THURS</th>
<th>FRI</th>
<th>SAT</th>
<th>SUN</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:30 AM</td>
<td>Breakfast</td>
<td>Breakfast</td>
<td>Breakfast</td>
<td>Breakfast</td>
<td>Breakfast</td>
<td>Breakfast</td>
<td>Breakfast</td>
</tr>
<tr>
<td>6:30 AM</td>
<td>i-pad white</td>
<td>i-pad white</td>
<td>i-pad white</td>
<td>i-pad white</td>
<td>i-pad white</td>
<td>Night with</td>
<td></td>
</tr>
<tr>
<td>7:30 AM</td>
<td>Mom walks</td>
<td>Mom walks</td>
<td>Mom walks</td>
<td>Mom walks</td>
<td>Mom walks</td>
<td>Mom walks</td>
<td>Mom walks</td>
</tr>
<tr>
<td>8:30 AM</td>
<td>Volunteer</td>
<td>Volunteer</td>
<td>Volunteer</td>
<td>Volunteer</td>
<td>Volunteer</td>
<td>Mom</td>
<td></td>
</tr>
<tr>
<td>8:30 AM</td>
<td>Fire Station</td>
<td>Fire Station</td>
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<td>Fire Station</td>
<td>Fire Station</td>
<td>Fire Station</td>
<td>Fire Station</td>
</tr>
<tr>
<td>9:30 AM</td>
<td>Go for walk</td>
<td>S-Noon</td>
<td>Buy food</td>
<td>S-Noon</td>
<td>Get ready</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30 AM</td>
<td>&amp; take to &amp; go to IHD</td>
<td>&amp; &amp; go to IHD</td>
<td>&amp; &amp; go to IHD</td>
<td>&amp; &amp; go to IHD</td>
<td>&amp; &amp; go to IHD</td>
<td>&amp; &amp; go to IHD</td>
<td>&amp; &amp; go to IHD</td>
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<tr>
<td>10:30 AM</td>
<td>Work</td>
<td>Good fam.</td>
<td>Volunteer</td>
<td>Church</td>
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</tr>
<tr>
<td>10:30 AM</td>
<td>@ Gym</td>
<td>Center</td>
<td>@ Gym</td>
<td>Gym</td>
<td>Gym</td>
<td>Gym</td>
<td>Gym</td>
</tr>
<tr>
<td>11:30 AM</td>
<td>Watch TV</td>
<td>Watch TV</td>
<td>Watch TV</td>
<td>Watch TV</td>
<td>Watch TV</td>
<td>Watch TV</td>
<td>Watch TV</td>
</tr>
<tr>
<td>11:30 AM</td>
<td>Lunch with</td>
<td>Lunch with</td>
<td>Lunch with</td>
<td>Lunch with</td>
<td>Lunch with</td>
<td>Lunch with</td>
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<tr>
<td>12:30 PM</td>
<td>FCA help</td>
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<td>FCA help</td>
<td>FCA help</td>
<td>FCA help</td>
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<tr>
<td>1:30 PM</td>
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<td>Library</td>
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<td>Watch TV</td>
<td>Watch TV</td>
<td>Watch TV</td>
<td>Watch TV</td>
<td>Watch TV</td>
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<tr>
<td>3:30 PM</td>
<td>Football</td>
<td>Football</td>
<td>Football</td>
<td>Football</td>
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<tr>
<td>4:30 PM</td>
<td>Practice</td>
<td>Practice</td>
<td>Practice</td>
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<td>Practice</td>
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<td>5:30 PM</td>
<td>Game</td>
<td>Dinner with</td>
<td>Dinner with</td>
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<td>Dinner with</td>
<td>Dinner with</td>
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<td>Do Wht</td>
<td>Matt (Din)</td>
<td>Matt (Din)</td>
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<td>Matt (Din)</td>
<td>Matt (Din)</td>
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<td>7:00 PM</td>
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<td>10:30 PM</td>
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<td>Riding</td>
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<tr>
<td>11:00 PM</td>
<td>Spend night with Matt at his apartment</td>
<td>Spend night with Matt at his apartment</td>
<td>Spend night with Matt at his apartment</td>
<td>Spend night with Matt at his apartment</td>
<td>Spend night with Matt at his apartment</td>
<td>Spend night with Matt at his apartment</td>
<td>Spend night with Matt at his apartment</td>
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February 2015
# Goal Attainment

## Charting the LifeCourse

**GOAL ATTAINMENT: Planning and Tracking Success**

**Goal:**

**Define Success:**
- Describe what **EXCEEDED** expected success would look like for this goal.

**Success Scale:**

- **Successes: What's Working**
- **Barriers and Challenges: What’s NOT Working**

**Strategies**

<table>
<thead>
<tr>
<th>STRATEGIES</th>
<th>SUPPORTS</th>
<th>START DATE</th>
<th>TARGET END DATE</th>
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</table>
Balancing Human and System Needs

Human Needs of Person and their Family

Touchpoints between Person/Family and LTSS
- Front Door Interaction
- Intake & Assessment
- Person Centered Plan Process
- Accessing Supports
- Delivering Services
- Check-In & Monitoring
- Annual Meeting

System Requirements (Federal, State, Organizational)
Putting the Framework into Action
Meet Mike...

About Mike
• 16-year-old young man who lives with parents and an older brother
• Attends XYZ high school and attends most general education classes (with the help of class within a class in several classes and one hour in the special education life skills classroom daily)
• Very social and loves being around his friends and classmates.

Interests:
• Mike likes anything and everything sports, especially enjoys football, baseball and basketball.
• Football and basketball manager for his middle school and high school teams.
• Wishes he could play on the HS sports teams but he doesn’t have the skill level or endurance needed.

Health:
• Mike gets tired if he is on his feet for too long, and does best when he can sit down frequently
• His mom says she doesn’t know if he has the endurance to work an 8-hour day.
• He has cerebral palsy and intellectual/developmental disability

Employment:
• When asked what kind of job he is interested in, he says he hopes he can someday work at Royals stadium. His mom reports he gets excited watching the Royals grounds crew before and during games
• Mike’s parents would love to see him employed as an adult, but they have no ideas about what is possible or what kind of a job would suit Mike
Discovering Who

- Adapted from The Learning Community for Person Centered Practices and Helen Sanderson Associates
- to learn more: http://helensandersonassociates.co.uk/person-centred-practice/one-page-profiles/one-page-profile-templates/

- List positive strengths, talents and qualities.
- Ask family or others who know you well for input

- People, places & things important to you.
- Hobbies, possessions, rituals, routines, family culture.
- What do you value most?

- Specific kinds of support that are helpful, and what is not.
- Support you need to create the best environment and outcomes in your life.
  - What is your preferred learning style?
  - What keeps you motivated?
  - How are you best encouraged?
Life Trajectory Worksheet

Past Life Experiences
List past life experiences and events that supported your vision for a good life.

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...

What I Don't Want
List the things you don't want in your life...
1. Describe Mike’s vision for overall “Good Life”

2. Then list what is not wanted
3. Current age
4. Past life experiences (positive or negative impact on trajectory)
5. Life experiences moving forward to try or avoid
Discovering How

Personal Strengths & Assets
- resources, skills, abilities
- characteristics

Technology
- i-pad/smart phone apps, remote monitoring, cognitive accessibility, Adaptive equipment

Relationships
- family, friends, neighbors, co-workers, church members, community members

Community Based
- school, businesses, church faith based, parks & rec, public transportation

Eligibility Specific
- SHS services, Special Ed, Medicaid, Voc Rehab, Food Stamps, Section 8
Discovering Who

Our Responses...

<table>
<thead>
<tr>
<th>What Do People Like and Admire About Me?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Social and friendly</td>
</tr>
<tr>
<td>• Helpful and enthusiastic</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>What Is Important to Me?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Family and friends</td>
</tr>
<tr>
<td>• Sports!</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What Are The Best Strategies To Support Me?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Make sure I am connected with friends and peers</td>
</tr>
<tr>
<td>• I need to sit or be able to take frequent breaks</td>
</tr>
</tbody>
</table>
Life Trajectory Worksheet

**Past Life Experiences**
LIST past life experiences and events that supported your vision for a good life.
- Living with mom/dad/brother who are supportive of interests
- Included in general ed classes with peers, with adaptations and accommodations
- Manager for MS/HS Football and basketball teams
- Attended/watched a lot of sports

**Future Life Experiences**
LIST current/future life experiences that continue supporting your good life vision.
- Explore working with HS grounds keepers and/or other sports related positions?

LIST life experiences to avoid because they push you toward things you don’t want.
- Jobs/experiences where can’t sit or take breaks to rest
- Job related experiences that don’t relate back to sports

**VISION for a GOOD LIFE**
LIST what you want your “good life” to look like...
- Being connected to family (mom, dad, brother)
- Being around friends and classmates
- SPORTS (football, baseball, basketball)
- Playing on the High School sports teams
- Working at Royals Stadium

My life course Portfolio is a template of the UMKC NSF, LSC200. More materials at lifecoursetools.com

UMKC Institute for
Human Development
Creating the Future You Want!
Discovering How

- Social
- Knowledgeable about sports
- Experience as team manager

Need to find out more information

- Parents
- Brother
- Teachers
- Coaches
- Classmates

- XYZ High School
- Sports teams/events

- Life Skills class
- Class within class

Access the LifeCourse framework and tools at lifecoursetools.com
Tips and Tricks

• You don’t have to FILL THE PORTFOLIO OUT in front of person/family
• The Portfolio doesn’t have to be completed in order - from front to back if it doesn’t make sense for a particular person or circumstance (find what works best for your style and the person you are working with)
• Could use Portfolio to take notes as you have a conversation
• Don’t have to “fill out” the entire portfolio – do what makes sense
• Sometimes you just use the framework to have conversations
• Could give it (in person or send ahead of time) to the person/family and ask them to look it over and get back with you to discuss
Using CtLC to Implement and Monitor Goals/Objectives
Goal Attainment: Planning and Tracking Success

**Goal:**

**DEFINE SUCCESS**
- Describe what DEFICITS expected success would look like for the goal.

**Success Scale**

- Barriers and Challenges: What's NOT Working
- Successes: What's Working

<table>
<thead>
<tr>
<th>STRATEGIES</th>
<th>SUPPORTS</th>
<th>START DATE</th>
<th>TARGET END DATE</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Developed by the UMKC Institute for Human Development, UCODE | more tools and resources at lifecoursetools.com June 2018
Achieving our Goals...

- Define expected success (3 stars) for a healthy living goal
- Describe what exceeding success (4 or 5 stars) and minimum success (1 or 2 stars) looks like
- Explore strategies and supports for success
- Reflect on what’s working/barriers to success in meeting goals
Goal Attainment Tool

- Step 1: Decide on a Goal
- Step 2: Define what Success looks like
- Step 3: Define Strategies to that will help you reach the goal
- Step 4: Describe the Integrated Supports who can help you practice the strategies
Life Trajectory Worksheet

**Past Life Experiences**
LIST past life experiences and events that supported your vision for a good life.
- Living with mom/dad/brother who are supportive of interests
- Included in general ed classes with peers, with adaptations and accommodations
- Manager for MS/HS Football and basketball teams
- Attended/watched a lot of sports

**Future Life Experiences**
LIST current/future life experiences that continue supporting your good life vision.
- Explore working with HS grounds keepers and/or other sports related positions?

**Vision for a Good Life**
LIST what you want your “good life” to look like...
- Being connected to family (mom, dad, brother)
- Being around friends and classmates
- SPORTS (football, baseball, basketball)
- Playing on the High School sports teams
- Working at Royals Stadium

**What I DON’T Want**
LIST the things you don’t want in your life...
- Being excluded from social and school activities with classmates
- Being unable to participate/watch sports
Mike’s Goal Attainment Sheet

Step 1: Decide on a Goal

Goals are part of our Vision for a Good Life

GOAL: Mike will gain work experience in a sports related field
Mike’s Definition of Success

Step 2: Define Success

• Sometimes, success means that we have reached our goal… what would that look like?

• Sometimes, success means that we are actively working on our goal… what would that look like?

Success means doing things that will help me reach my goal.
Mike’s Strategies

- How will you be successful?
- What can you do?
- When will you do it?
- Where will you do it?
- How often will you do it?
- Who can help you?
- What do you need to do?

Success means doing things that will help me reach my goal.
Identify Supports

What supports can be leveraged for action strategies?

Using Integrated Supports helps me to do things that make me successful.

Charting the LifeCourse Integrated Supports Star: Mapping

- **Technology**
  - Social
  - Knowledgeable about sports
  - Experience as team manager

- **Personal Strengths & Assets**
  - Need to find out more information

- **Relationships**
  - Parents
  - Brother
  - Teachers
  - Coaches
  - Classmates

- **Community**
  - XYZ High School
  - Sports teams/events

- **Eligibility Specific**
  - Life Skills class
  - Class within class

Using Integrated Supports helps me to do things that make me successful.
**Identify Supports**

What supports can be leveraged for action strategies?

Using Integrated Supports helps me to do things that make me successful.

---

### GOAL: Mike will gain work experience in a sports related field

<table>
<thead>
<tr>
<th>STRATEGIES</th>
<th>SUPPORTS</th>
<th>START DATE</th>
<th>TARGET END DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shadow grounds crew</td>
<td>XYZ High School</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify other potential positions to shadow</td>
<td>Job Skills Class</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shadow in additional positions of interest</td>
<td>Coaches</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Developed by the UMKC Institute for Human Development, LCEDC | More tools and resources at lifecoursetools.com | Updated DEC 2016**
Tracking Success

CHARTING the LifeCourse

GOAL ATTAINMENT: Planning and Tracking Success

GOAL: Mike will gain work experience in a sports related field

<table>
<thead>
<tr>
<th>DEFINE SUCCESS</th>
<th>Success Scale</th>
<th>STRATEGIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe what SUCCESS expected success would look like for this goal: Mike will have 1 or more paid work experiences</td>
<td></td>
<td>Shadow grounds crew</td>
</tr>
<tr>
<td>Describe what EXPECTED SUCCESS looks like for this goal: Mike will volunteer in 3 settings</td>
<td></td>
<td>Identify other potential positions to shadow</td>
</tr>
<tr>
<td>Describe what MINIMUM success would look like for this goal: Mike will shadow at least 1 setting</td>
<td></td>
<td>Shadow in additional positions of interest</td>
</tr>
</tbody>
</table>

Successes: What’s Working
5: Shadow at ABC Park – loved the mower
21: shadowed Master Gardner – enjoyed spreading mulch

Barriers and Challenges: What’s NOT Working
14: Volunteered at Boys and Girls club – did not enjoy basketball

START DATE TARGET END DATE
Comprehensive, Integrated & Coordinated Across All Life Domains and Stages

Pediatrician, Families and Friends, Faith based

IDEA Part C, Parents as Teachers, Health, Headstart

School, Special Education, Health, Recreation

Vocational Rehab, Health, Employment, College, Military

Disability Services, Health, Housing, College, Careers

Retirement, Aging System, Health
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 and Forms
Vision for a Person Centered System

In the RIGHT box... write your vision for DSPD
Vision for a Person Centered System

In the RIGHT box... write what you DON’T want for DSPD
ASSET MAPPING AND COMMUNICATIONS STRATEGY
Communication Plan:
Our Guiding Principles (1 of 2)

• We believe that “least restrictive” setting is the right place for all individuals to live, regardless if one has a disability or not.

• We believe that individuals and families, once educated, will see the opportunities afforded to them through the HCBS Setting Rule.

• We believe families deserve to be together and to make choices.

• We believe individuals should be given more opportunities to live, work, and socialize within the communities they live as a result of our HCHS Setting changes.
Communication Plan:  
Our Guiding Principles (2 of 2)

• We understand that many people feel comfortable where they live and want to stay there; our policies and practices needs to respect all informed choices.

• We understand it is our responsibility to get all stakeholders to the table, informing them of the HCBS Settings Rule and engaging them in systems change.

• We believe the HCBS Settings Rule will inform and enhance our existing system of support, leading to enhanced quality of life of those we support.
Communication Plan:
Our Short-Term Goals

• Educate service users, families, self-advocates, advocates, providers, and state agency partners about the HCBS Settings Rule and the re-design process.

• Provide concrete strategies for service users, self-advocates, and families to be the driving force in the redesign process.

• Support providers to understand the opportunities afforded to them under the HCBS Settings Rule.

• Provide concrete strategies to support providers to become compliant with the HCBS Settings Rule.
Communication Plan: Some Obstacles to Communication

• This topic does not impact me
• I don’t have anything to give to this process
• I don’t have internet
• This information is too complicated
• I need help accessing this information, but you don’t know how to help me
Communication Plan: Our Methods

How should we communicate with stakeholders about the HCBS Settings Rule and Future Systems Change Needs?
Stakeholder Engagement

Asset Mapping

• Engagement often already happening, but knowledge of what is occurring and who is leading is not known system-wide

• Asset Mapping allows you to take a ‘snapshot’ of your system and engagement efforts

• Asset Mapping includes both written and visual displays of your existing stakeholder engagement assets

• Asset Mapping informs steps required to improve engagement methods while also building on the resources already in place
Asset Mapping Process

1. Define your Scope
2. Clarify your Target Groups
3. Define your Terms
4. Brainstorm Existing Initiatives
5. Search for Information
6. MAP!
Our Asset Mapping Focus

We want to...

- Understand our existing strategies to engage service users, self advocates, family members, and advocates.
- Focus on individuals who are accessing or would like to access home and community-based services through Medicaid Waivers, including individuals who are living in Intermediate Care Facilities (ICFs).
Our Asset Mapping Focus

<table>
<thead>
<tr>
<th>Clarifying our Target Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Users</td>
</tr>
<tr>
<td>Family Members</td>
</tr>
<tr>
<td>Self Advocates</td>
</tr>
<tr>
<td>Advocates</td>
</tr>
</tbody>
</table>
Sample of our Assets for Engaging Service Users & Family

- What Disability Groups are Not Well Represented in this Visual?
- Can you think of other Assets to add?
Sample of our Assets for Engaging Self Advocates

- What Disability Groups are Not Well Represented in this Visual?
- Can you think of other Assets to add?
Sample of our Assets for Engaging Advocates

- **What Disability Groups are Not Well Represented in this Visual?**

- **Can you think of other Assets to add?**
Vision for Provider’s Role

In the RIGHT box... write what you want for providers

What I DON'T Want
LIST the things you don't want in your life...
Vision for a Person Centered System

In the RIGHT box... write what you DON’T want for providers
BREAK

Please put your post-its on the Asset Map Papers around the room.
Reflections and Questions
Aha! Moments

• What is one thing you can do in your own life or role?

• What is one thing your organization can do?

• What is one change you would like to see at the system level?
Thank you.
Stay in touch at https://ncapps.acl.gov

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