NCAPPS

Five Competency Domains for Staff Who Facilitate Person-Centered Planning

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Introduction

Person-centered planning (PCP) is a way to learn about the choices and interests that make up a person's idea of a good life—and to identify the supports (paid and unpaid) needed to achieve that life. It is not something you do *to* a person, nor is it something you do *for* a person; instead, it is directed by the person, *with* support from a facilitator as needed and desired. The facilitator might be a case manager, support coordinator, clinician, peer specialist, or another independent staff person who is specifically tasked with helping to co-create a person-centered plan.

The methods used to undertake person-centered planning may vary based on the unique structures of systems and the unique needs and preferences of the people they support. But in all circumstances, the relationship between the person and the facilitator is a mutually respectful partnership where the plan is co-created with the goal of helping the person realize their unique vision of a good life.

To date, there are no universally agreed upon standards, or competencies, for human service agency staff tasked with facilitating person-centered planning. Such standards are needed to ensure the planning process is consistent with the values and principles of person-centered thinking, planning, and practice. This resource describes five skill areas, or domains, that facilitators should possess to support a fully person-centered planning process.

This resource was created as part of technical assistance provided by the National Center on Advancing Person-Centered Practices and Systems (NCAPPS). It builds from the rich history of [foundational approaches to person-centered planning](#) as well as the 2020 [Person-Centered Planning and Practice Final Report](#) from the National Quality Forum (NQF), which outlines a set of core competencies for person-centered planning facilitation, identified by a multi-stakeholder expert panel. See Appendix A for a full list of resources that were used to establish the five domains presented here.

Five 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 Monitoring

Who It's For

This resource is for human service agency leadership who oversee the organization and delivery of services and supports. It applies to a wide range of systems supporting individuals with various types of disabilities, people with behavioral health-related needs, and older adults with long-term service and support needs. The five competency domains can inform hiring, training, and supervision; quality improvement activities; and other systems change initiatives.

The information in this document is also useful for people who receive services and their loved ones. The five domains described here give people an idea of the type of partnership they should expect when working alongside people who facilitate and support the person-centered planning process.

A Note About Systems and People

Staff competency in PCP is only one aspect of a larger system that is needed to support person-centered thinking and planning. To be truly person-centered, human service systems must have policies, procedures, and infrastructure that support engagement, equity, access, coordination, self-direction, community inclusion, and a range of other factors. Even the most competent and committed PCP facilitators will not be able to fully actualize their competency in practice in the absence of systems characteristics that align in support of person-centered planning. These characteristics are discussed in the recent report from the National Quality Forum; forthcoming NCAPPS resources will provide additional support for measuring, implementing, and promoting person-centered systems.

Finally, it is critical to remember that person-centered planning is, first and foremost, about the person, not the facilitator or the system. Although this particular resource focuses on the skills of people who help to facilitate person-centered planning, this focus should not be taken as diminishing the primary role of the person who should always be at the center of the planning process.

How We Arrived at the Domains

This work began with 16 national sources that outline essential skills, practice standards, federal regulations, and learning objectives for person-centered thinking, planning, and practice from a range of fields, including intellectual and developmental disability services, behavioral health services for adults and children/youth, and aging and physical disability services. These source documents are listed in Appendix A.

The work was led by Janis Tondora of the Yale University Program for Recovery and Community Health. The team also included NCAPPS staff from the Human Services Research Institute who collectively brought a wide range of both professional

expertise and lived experience to the process. The team used thematic analysis, a qualitative research approach, to organize the material and develop the domains.

In extracting 400 potential competencies from the 16 source documents, it became clear to us that different service systems were using different terms to describe similar concepts. In the behavioral health field, for example, "recovery-oriented" is analogous to "person-centered" in describing systems that provide individualized, holistic supports focused on promoting a desired life in the community. It also became clear that there were several areas that were valued across *all* sources—based on the frequency with which they appeared and their salience to the values and principles of person-centered thinking, planning, and practice. These commonly identified themes were proposed by the team lead (Janis Tondora) as an initial set of competency domains and shared with the remaining NCAPPS team (Bevin Croft, Yoshi Kardell, Teresita Camacho-Gonsalves, and Miso Kwak) along with a master spreadsheet that assigned or "coded" each of the 400+ potential competencies according to the specific domain they seemed most closely aligned with.

Next, all members of the team reviewed the team lead's spreadsheet, making note of whether they agreed with the initial domain coding and/or whether other domains might be more applicable. Across all team members, there was a high degree of agreement in the coding across over 90% of the items. This high level of agreement supports the reliability of the process and the coding structure. Any discrepancies in the domains or the individual coding of competencies were then discussed by the full team in a series of working meetings until there was a consensus-based opinion on a set of five competency domains presented here.

Next, the team met with three members of NCAPPS' Person-Centered Advisory and Leadership Group (PAL Group). After reviewing the process and the domains, the PAL Group members were asked whether the information presented here resonated with their experiences of person-centered planning. The PAL Group members provided the team with valuable feedback that led to further revision of this document and the descriptions of the domains.

Five Competency Domains

In this section we describe the underlying principles and assumptions of each of the Domains and present a numbered list of associated competencies, which were informed by the original source documents.

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 Monitoring

Five Person-Centered Planning Competency Domains

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

Person-centered planning recognizes that people grow, change, and can realize personally valued goals. PCP focuses on the universally valued goal of living a good life as defined by the person. All activities focus on the person as a whole (not just their diagnosis or disability) and are informed by the person's unique culture and identity.

1. Demonstrates self-awareness and practices cultural humility. Person-centered practitioners must be cognizant of their own power and privilege, cultural assumptions, psychological development and temperament, personality dynamics, and prejudices to avoid imposing their beliefs on the process. Similarly, practitioners are aware of the values and cultural biases of the service system and recognize that the person's values and culture may not align with the system's values and culture.

2. Learns about a person's cultural and linguistic preferences and experiences of trauma (personal or historical) and draws on this learning when partnering with the individual in the planning process. Recognizes cultural and linguistic factors such as individualism and collectivism, language and communication, values and beliefs, customs and rituals, relationships to authority figures, avoidance of uncertainty, relationships to time, and other cross-cultural differences that need to be understood and respected in the person-centered planning process and its goal of community inclusion.

3. Skillfully uses available person-centered tools to support goal discovery, visioning, and self-direction.

4. Conveys high expectations for meaningful outcomes across a broad range of quality of life areas valued by the person that go far beyond the management of a disability or diagnosis.

5. Creates a comprehensive, strengths-based profile with the person that helps them discover or rediscover themselves as a whole person with strengths and interests beyond their disability or diagnosis.
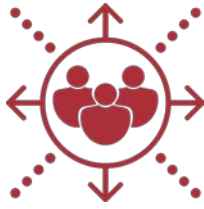
B. Cultivating Connections Inside the System and Out

Planning facilitates linkages with both paid (professional) and unpaid (natural) supports. This requires understanding of the person's relevant health or disability issues as well as knowledge of the array of systems the person may access. All activities seek to maximize connections to natural community activities and relationships in inclusive settings wherever possible and when consistent with the preferences of the person.

1. Understands the systems and supports a person may choose to access (e.g., LTSS) and facilitates linkages as appropriate, e.g., to health care, social services, entitlement programs, recreation and leisure, housing and employment supports, faith-based opportunities, employment resources, culturally specific resources, and safety net providers such as food pantries and clothing donations.

2. Understands basic issues related to different populations served, e.g., older adults and people with physical disabilities, intellectual/developmental disabilities, mental health challenges, brain injury, or Alzheimer's disease or cognitive impairment.

3. Promotes the person's connection to the valued natural community activities and relationships that matter most to them. Encourages a person's experiences and activities beyond those provided in segregated environments designed only for people with disabilities or specific diagnoses.

4. Actively involves family caregivers and/or other supporters in collaboratively developing and executing the person-centered plan in accordance with the preferences of the person.

5. Supports the creation or maintenance of a meaningful life in the community (as defined by each individual) as a fundamental human right and not something that must be earned by the demonstration of "stability" or acts of compliance with professional recommendations.

C. Rights, Choice, and Control

Relationships and planning activities are based on respect and the assumption that people are presumed competent and have the right to control decisions that impact their lives. Practitioners support people in empowering themselves and discovering their voice in all aspects of plan co-creation and implementation. Practitioners are aware of and able to educate people (when necessary and desired) about the range of legal protections that promote both fundamental safety (i.e., the right to be free from abuse and neglect) and community inclusion (i.e., the right to be free from discrimination and the right to exercise freedoms).

1. Presumes competence. All people are presumed to have the capacity, and the right, to actively participate in the planning process.

2. Understands the concepts of dignity of risk and the right to fail. With the exception of some emergency situations, does not (directly or indirectly) place limits or restrictions on a person's freedom or activities out of a desire to protect them or act in their best interest.

3. Provides basic education about one's rights in services (including the right to receive conflict-free case management when supported by Medicaid-funded home and community-based services) as well as one's right to be free from discrimination both within the service system and in the community at large. This requires a basic knowledge of the history and achievements of advocacy groups across disability and aging at the national level—including the passage of rights legislation such as the Americans with Disabilities Act (ADA), Olmstead, the Patient Self-Determination Act, etc.

4. Supports people to advocate for themselves (and/or advocates for them when appropriate and desired) when their preferences or values are not being honored in the person-centered planning process and during times of tension or disagreement with providers or supporters.

5. Practices supported decision-making, a series of relationships, interventions, arrangements, and agreements designed to assist a person to make and communicate to others decisions about their life, often around alternatives to guardianship and other legally sanctioned restrictions to freedom for people with disabilities.

6. Understands how to recognize abuse, neglect, and exploitation and the legal and administrative requirements related to the handling and reporting of such violations.

D. Partnership, Teamwork, Facilitation, and Coordination

Planning interactions and meetings are facilitated in a respectful, professional manner and in accordance with person-centered principles and the preferences of each individual. Ensures the primary focus remains on the priorities and perspective of the person. Supports the person in expanding their team or circle as desired. Encourages all members to make meaningful contributions and facilitates the process in a way that is transparent and accessible to all parties involved.

1.   Attends to language and respects the preferences of the person. Understands the nuances behind person-first vs. identity-first language.

2.   Respects the person's input regarding the planning meetings, including who the person would like to involve, preferences around logistics (location, schedule, etc.), priority areas for discussion, and preferences around facilitation (e.g., self-facilitated or supported).

3.   Facilitates one-on-one or team meetings in a respectful, professional manner and works to ensure the person's preferences shape the process. Meetings start on time; disruptions are minimized; the person is given the team's full attention; the conversation follows the person's lead; the person is never "talked about" as if they are not in the room, and conversations and questions are directed to their attention; the facilitator regularly checks in with the person during planning conversations to be sure they understand and to ask if they have questions; the person is always offered a copy of their plan and given a copy to review, edit, and suggest changes if it does not reflect their input.

4.   Makes space for the contributions of all team members during person-centered planning meetings, with a particular priority of making sure the person's voice is not lost in the dialogue and is given primary consideration.

5.   Understands and knows how to help the person and their supporters identify and work through differences and conflicts. Able to facilitate agreement, or respectful disagreement, among all involved on course of action using tools and techniques such as conflict resolution and decision support.

6.   Maintains a focus in the conversation on the person's desired life goals and outcomes.

E. Person-Centered Plan Documentation, Implementation, and Monitoring

The person-centered plan is co-created and captured in writing in a manner that adheres to established expectations around person-centered plan documentation. The plan is valued as a "living document" that is revised as needed based on the person's preferences and evolving situation. There is responsible follow-up and monitoring of the plan's implementation.

1. Actively includes the person's strengths, interests, and talents in their plan and its implementation.

2. Writes plans using the person's preferred name and language and identity preferences throughout.

3. Frames goal statements using language that is clear and accessible while capturing what is important to the person in their own words wherever possible.

4. Reflects the services and supports (paid and unpaid) in plan documentation that will assist the person to achieve identified goals. If the person chooses, coordinates efforts between paid and unpaid (natural) supporters during plan implementation.

5. Solicits ongoing feedback from the person and their supporters on progress and concerns and revises the plan as needed in an expedient manner.

6. Monitors and oversees the implementation of the plan to ensure that services are delivered both in accordance with the person's preferences and in accordance with the type, scope, amount, duration, and frequency of supports as specified in the plan.

How to Use This Resource

Below are examples of how a human services agency or system might incorporate the five competency domains into its workflow and business practices to support person-centered planning implementation.

1. **Person-Centered Planning Trainings:** Crosswalk the competency domains with the existing person-centered planning training curricula to ensure they are adequately addressed through educational content, experiential exercises, and the provision of person-centered tools and resources. When needed, a training curriculum can be enhanced by drawing on content, exercises, and tools from other training models. In our review, we observed that a range of tools are employed across human services systems to support person-centered planning. These tools have often been developed with specific populations or groups in mind, though they may have broader relevance. In Appendix B, we have listed commonly used tools that are relevant for each domain.

2. **Quality Improvement and Monitoring:** Align quality improvement and monitoring tools with competency domains to ensure both process and documentation are consistent with person-centered principles.

   a) Carry out observational audits to assess process-based competency domains in one-on-one or team-based person-centered planning meetings.

   b) Complete systematic chart reviews to ensure the competency domains are reflected in the documentation of person-centered plans.

   c) Assess the person-centered quality of both the process and the documentation directly from the participant perspective through the use of parallel quality measurement tools and/or focus groups.

   d) Ensure that quality monitoring of person-centered planning is not limited to the evaluation of *process* but includes careful attention to whether or not adherence to PCP leads to the achievement of the personally valued goals and meaningful life *outcomes* desired by people receiving services.

3. **Implementation of Person-Centered Plans:** Use competency domains, participant feedback, and quality measurement data to support person-centered planning implementation in the following ways:

   a) Inform the development of job descriptions and other human resources activities, e.g., recruitment and hiring, performance evaluation and promotion, etc.

   b) Make person-centered planning expectations transparent for all staff and support staff through ongoing supervision in meeting these expectations.

c) Identify workforce development needs, and align training resources and content with specific competency areas in need of development.

d) Identify "exemplar" staff and programs that can model and support peers in the implementation of person-centered planning.

e) Educate and empower people so they are fully informed as to what they should expect in a quality person-centered planning process.

f) Promote dialogue around a shared quality vision of person-centered planning across all systems stakeholders, e.g., collaborating service agencies, managed care organizations and other funders, local university and human-service certification programs.

Concluding Thoughts & Future Discussion

This resource was created for the purpose of clarifying essential skills and abilities that are necessary to effectively facilitate person-centered planning in support of, and alongside, people receiving services. The focus on staff competencies across five primary domains should not be taken to suggest that PCP is a mechanistic set of behaviors and that rigid adherence to this set of behaviors is the "right" way to do person-centered planning. To suggest there is any one "right" way to do PCP would be antithetical to the spirit of the approach. Truly, person-centered planning involves a dynamic mix of maintaining fidelity to person-centered practices while also flexing those practices to reflect a person's unique preferences.

At the same time, the articulation of staff competencies makes way for a wide range of practice and research-based efforts to further support the implementation of person-centered planning. For example, future research is needed to explore how adherence to core competencies in person-centered facilitation impacts a person's experience in services. More importantly, do improvements in these areas lead to meaningful outcomes around things such as community inclusion and belonging, empowerment and independence, natural support relationships, and the attainment of personally valued goals? And is it possible that high-quality person-centered planning facilitation can lead not only to desired outcomes for persons served but also to fiscal savings on the part of the systems that serve them? That is, might person-centered approaches reduce reliance on high-intensity, high-cost interventions that are often associated with the traditional problem-driven approaches to long-term services and supports? Finally, it is imperative that all research and practice-based implementation efforts proceed with fully participatory methods in keeping with the "nothing about us without us" dictum that has been the bedrock of person-centered planning since its inception. The "how" we study and implement is equally important to the "what" we choose to study and implement. People with lived experience must be engaged as partners in all aspects of the transformation process if the full potential of person-centered planning is ever to be realized.

About NCAPPS

The National Center on Advancing Person-Centered Practices and Systems (NCAPPS) is an initiative from the Administration for Community Living and the Centers for Medicare & Medicaid Services to help States, Tribes, and Territories to implement person-centered practices. It is administered by the Human Services Research Institute (HSRI) and overseen by a group of national experts with lived experience (people with personal, first-hand experience of using long-term services and supports).

NCAPPS partners with a host of national associations and subject matter experts to deliver knowledgeable and targeted technical assistance.

You can find us at https://ncapps.acl.gov

Appendix A: Sources Used in This Review

1. National Quality Forum. [Person-Centered Planning and Practice Final Report](#)

2. Charting the LifeCourse Nexus, University of Missouri Kansas City Institute for Human Development. [Charting the LifeCourse Framework and Tools](#)

3. Evaluation of the [Person-Centered Counseling Training Program](#) Pilot (for professionals working in the NWD system), Lewin Group, University of Minnesota

4. Administration for Community Living. [Person-Centered Counseling Training Program](#)

5. [Learning Community for Person-Centered Practices](#). Person-Centered Thinking Training

6. Boston University, School of Social Work, Center for Aging & Disability Education and Research (CADER). Course [Understanding Consumer Control, Person-Centered Planning, and Self-Direction](#)

7. Michigan Department of Health and Human Services. [Person-Centered Planning for Home and Community-Based Long Term Supports and Services:, Practice Guidance for MI Choice Waiver Agencies, 2015](#)

8. Partnering for Recovery in Mental Health: A Practical Guide to Person-Centered Planning. Tondora, J., Miller, R., Slade, M., & Davidson, L. Wiley-Blackwell, London, 2014. Additional tools and resources available from janis.tondora@yale.edu.

9. Home and Community-Based Services (HCBS) Settings Final Rule. [42 C.F.R. § 441.301(c)(1) and §441.301(c)(2)(xiii), 2014](#)

10. Centers for Medicate & Medicaid Services. [Application for a §1915(c) Home and Community Based Waiver: Instructions, Technical Guide and Review Criteria, 2019, pp.190-201](#)

11. US Department of Health and Human Services. [Guidance to HHS Agencies for Implementing Principles of Section 2402(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs; 2014](#)

12. US Department of Veterans Affairs. Patient and Family Centered Care and [Whole Health Courses](#) ([Overview](#) and [3-Day Experiential Training](#))

13. W.K. Kellogg Foundation. [Family-Centered Coaching: A Toolkit to Transform Practice & Engage Families](#)

14. Human Services Research Institute. [Person-Centered Thinking, Planning, and Practice: A National Environmental Scan of Indicators](#)

15. National Quality Forum. [Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement, Final Report](#)

16. The National Center for Innovation and Excellence, [High-Fidelity Wraparound Training Institute: Certification Track 1: Competency Based Practitioner Certification](#)

Appendix B: Competency Domains & Associated Tools

A note about tools: In developing these competencies, the goal is not to focus on or require the use of any specific tool or person-centered planning model; rather, the focus is on ensuring the PCP facilitator possesses desired skills. The use of a tool is simply one way of demonstrating this skill. The person-centered use of any given tool is only as strong as the values and competencies of the practitioner employing it. For this reason, formal training in person-centered thinking, planning, and practice is strongly recommended prior to using the tools listed here.

Domain	Tools*
A: Strengths-Based, Culturally Informed, Whole Person–Focused	- Life Trajectory[1] - Life Domain Vision Tool[1] - Family Vision Planning[1] - Good Day/Bad Day[2] - Relationship mapping[2] - Gifts and Capacities[3] - Important to/Important for[2,3] - One-Page Profile[2,3] - Community Mapping[3] - Presence to Contribution[3] - Circle of Health Personal Health Inventory[15] - Recovery Roadmap: Strengths-based Person-Centered Inquiry[4] - Wellness Recovery Action Planning (WRAP)[5] - Wheel of Life/Plan-Do-Review[8] - Personal Medicine Model/Tools[9] - Tools for Transformation Series: Person First Assessment and Person Directed Planning[13]
B: Cultivating Connections Inside the System and Out	- Integrated Support Star[1] - Reciprocal Roles[1] - Presence to Contribution[3] - Community Mapping[3] - Community Inclusion tools[10] - Jump-Starting Community Inclusion: A Toolkit for Promoting Participation in Community Life[11]
C: Rights, Choice, and Control	- Integrated Support Star for Supported Decision Making[1] - Decision making profile[3] - Decision making agreement[3] - Important To/Important For[3] - Psychiatric Advanced Directives[6] - Driver's Seat Toolkit for people with behavioral health conditions[7] - This Is Your Life: Creating Your Self-Directed Life Plan[12] - Considering the Role of Antipsychotic Medications in My Recovery Plan[14]

Domain	Tools*
D: Partnership, Teamwork, Communication, and Facilitation	- Doughnut exercise[2,3] - Matching tool[2,3] - Communication Charts[3]
E: Person-Centered Plan Documentation, Implementation, and Monitoring	- Learning Log[2] 4+1 questions[2,3] - What's Working/Not Working[2,3] - Recovery Roadmap Tips Series[4]

*Tools can be accessed at these locations:

1. Charting the LifeCourse Nexus, University of Missouri Kansas City Institute for Human Development: https://www.lifecoursetools.com/lifecourse-library/foundational-tools/
2. Support Development Associates: https://www.sdaus.com/tool-kit-templates-examples
3. Helen Sanderson and Associates: http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/
4. Person-Centered Recovery Planning in Behavioral Health, available from janis.tondora@yale.edu
5. Wellness Recovery Action Plan: https://mentalhealthrecovery.com/
6. National Resource Center on Psychiatric Advance Directives: https://www.nrc-pad.org/
7. Getting in the Driver's Seat of Your Treatment: Preparing for Your Plan: https://cdn.ymaws.com/www.fadaa.org/resource/resmgr/files/resource_center/Getting_In_Drivers_Seat.pdf
8. Living Well in My Community (Workbook): https://www.tri-counties.org/living-well-in-my-community/
9. Pat Deegan's CommonGround website (Personal Medicine): https://www.commongroundprogram.com/ and https://www.recoverylibrary.com/assets/browser_test/personal_medicine_worksheet.pdf
10. Temple University Collaborative on Community Inclusion: http://www.tucollaborative.org/community-inclusion-resources/
11. Temple University Collaborative on Community Inclusion, *Jump-Starting Community Inclusion: A Toolkit for Promoting Participation in Community Life*: http://www.tucollaborative.org/wp-content/uploads/Jump-Starting-Community-Living-and-Participation.pdf
12. Center on Integrated Health Care and Self-Directed Recovery: https://www.center4healthandsdc.org/self-directed-recovery.html
13. Philadelphia Department of Behavioral Health and Mental Retardation Services (DBHMRS): http://dbhids.org/wp-content/uploads/2015/07/The-Tools-for-Transformation-Series-personFirst.pdf
14. Substance Abuse and Mental Health Services Administration (SAMHSA) Shared Decision Making Tools: https://www.samhsa.gov/brss-tacs/recovery-support-tools/shared-decision-making
15. U.S. Department of Veterans Affairs Personal Health Inventory: https://www.va.gov/WHOLEHEALTH/phi.asp