NCAPPS

Five Competency Domains for Person-Centered Planning

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Introduction

Person-centered planning is a dynamic way to learn about the choices and interests that make up someone's idea of a good life — and to identify the services and supports needed to achieve that life. It is not something you do *to* a person, nor is it something you do *for* a person; instead, the person directs person-centered planning *with* support from a facilitator as needed and desired.

To date, there are no universally agreed upon standards, or competencies, for person-centered planning facilitators. 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 collectively constitute a quality person-centered planning process.

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

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 as 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.

Who It's For

This resource is for human service agency leaders who oversee the organization and delivery of services and supports. It applies to a wide range of systems supporting people with various types of disabilities as well as those 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 family of choice. The five domains described here provide insight on the type of partnerships they should expect when working alongside those who facilitate and support the person-centered planning process.

Notes About People and Systems

Person-centered planning methods may vary based on system structures and the unique needs and preferences of the people they support. In some cases, person-centered planning may be best facilitated by a trusted family member, friend, or other natural ally (e.g., a representative from a faith community). This facilitator operates independently of the service system and collaborates with the person and their chosen supporters to develop the person-centered planning. Historically, these trusted individuals were referred to as "natural supporters," distinguishing them from paid human service workers. More recently, people with lived experience have suggested the term "family of choice" to reflect the role of individuals welcomed into their support network.

The person-centered planning process may also be facilitated by a service system professional. These workers operate within paid roles, such as care manager, clinician, peer specialist, or designated person-centered planning facilitator and advocate. In all circumstances, the plan results from a mutually respectful partnership and reflects the person's unique vision of a good life.

In practice, these competency domains may look different depending on the parties involved. In many cases, a primary person-centered planning facilitator will be responsible for all five domains of practice. However, when the chosen facilitator is a family member, friend, or other ally, it may be the case that they do not have direct responsibility for some domains. For example, a person may elect to have a close friend serve as person-centered planning facilitator. The friend may facilitate inclusive team conversations, amplify the person's voice, and work to ensure that all efforts further the person's vision of a good life. However, the friend may not be the team member who documents plan, delivers services outlined within it, or monitors its implementation; in

this case, the facilitator may rely on the commitment and skill of another team member. To realize the true potential of person-centered planning, it is incumbent on ALL team members to appreciate the competency domains and to contribute accordingly based on their role.

Competency in person-centered planning facilitation is only one aspect of a larger system required to support person-centered thinking and planning. To be truly person-centered, human service systems must have policies, procedures, and infrastructure that bolster engagement, equity, access, and coordination. Where system characteristics align with person-centered values, facilitators may make most effective use of their skills.

The NCAPPS Person-Centered Practices Self-Assessment is designed to help human service agency leaders measure their progress in developing a more person-centered system. It contains questions about observable practices across eight system domains:

- Leadership
- Person-centered culture
- Eligibility and service access
- Person-centered service planning and monitoring
- Workforce capacity and capabilities
- Collaboration and partnership
- Quality and innovation
- Finance

Finally, it is critical to remember that person-centered planning is, first and foremost, about the person and their goals for a good life. Although this resource highlights the skills of people who facilitate person-centered planning, its focus should not be taken as diminishing the role of the person who should always be centered in the process.

How We Arrived at the Domains

This work began with 16 national sources that outline skills, standards, regulations, and learning objectives for person-centered thinking, planning, and practice; they span 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.

Janis Tondora of the Yale University Program for Recovery and Community Health led the work. The team included NCAPPS staff from the Human Services Research Institute, who

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

Through the process of extracting 400 potential competencies from the 16 source documents, it became clear that different service systems used 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. The team also observed several areas valued across *all* sources — based on the frequency of appearance and salience to the principles of person-centered thinking, planning, and practice.

Janis Tondora, team lead, proposed the commonly identified themes as an initial set of competency domains and shared them with team members Bevin Croft, Yoshi Kardell, Teresita Camacho-Gonsalves, and Miso Kwak. A master spreadsheet assigned or "coded" each of the 400-plus potential competencies according to the domain with which they were most closely aligned.

Next, all team members reviewed the spreadsheet, noting 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 items. This high level of agreement supports the reliability of the process and the coding structure.

Through a series of working meetings, the team discussed any discrepancies in domains or coding until there was a consensus-based opinion on the set of five competency domains presented here. The team then met with three members of NCAPPS' Person-Centered Advisory and Leadership Group (PAL Group). After reviewing the process and domains, the PAL Group members were asked whether the presented information 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.

The first version of this document was published in November 2020. The present version includes revisions based on feedback from people with lived experience, experts in person-centered planning and cultural competence, and human service agency staff who have been using the domains to enhance person-centered planning within their systems.

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.

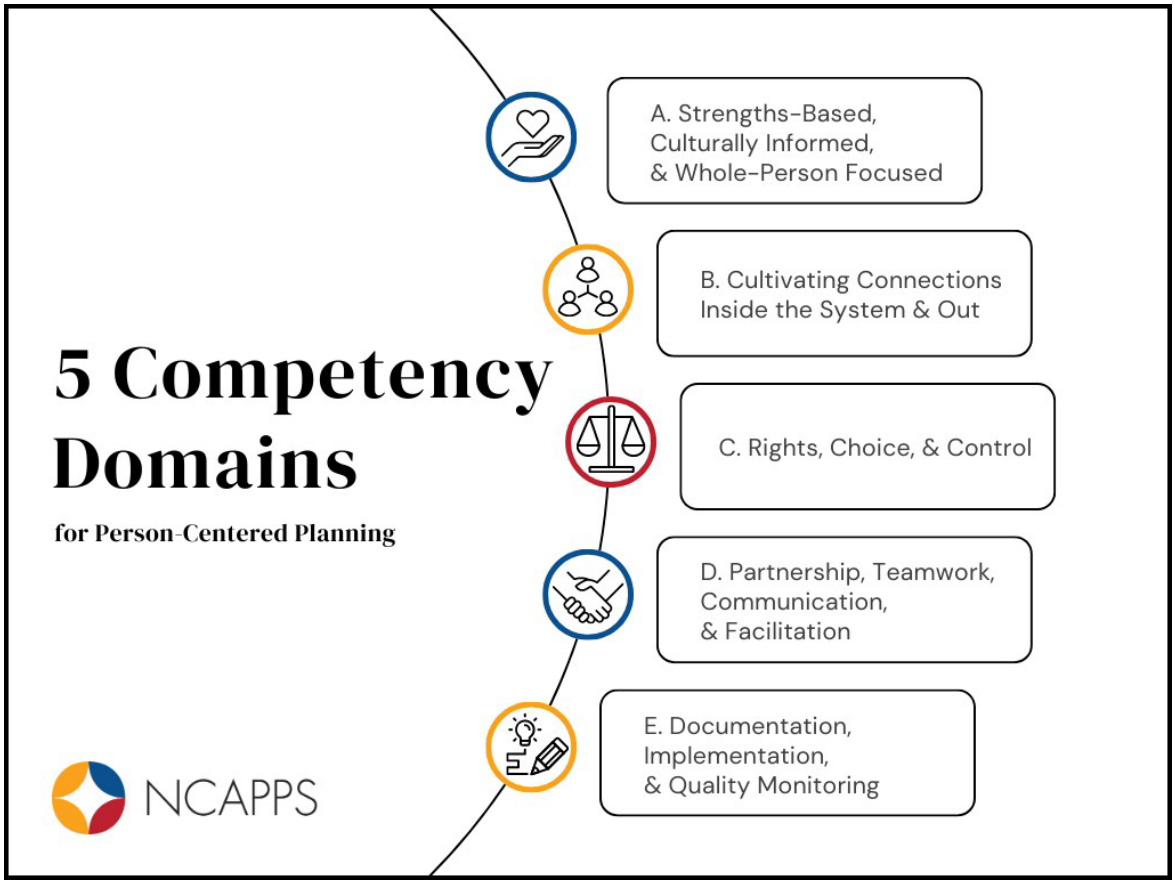

Figure 1. 5 Competency Domains for Person-Centered Planning. Click on a box or icon to skip to a domain section.

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

Person-centered planning recognizes that people grow, change, and can realize personally valued goals. Person-centered planning 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.

A facilitator competent in this domain:

- Demonstrates self-awareness and practices cultural humility. Person-centered practitioners are 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.
- 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 person 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.
- Skillfully uses available person-centered tools to support goal discovery, visioning, and self-direction.
- Draws on communication, technology, and relationship mapping tools to guide the discovery process for people who use alternative and augmentative communication.
- 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.
- Creates a comprehensive, strengths-based picture of the person that includes their unique skills, talents, interests, and preference. This picture 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, including formal and natural supports the person may access (e.g., spiritual groups, poetry clubs, hiking clubs, sweat lodges, etc.). All activities seek to maximize connections to natural community activities and relationships in inclusive settings wherever possible, consistent with the preferences of the person.

A facilitator competent in this domain:

Understands the systems and supports a person may choose to access (e.g., long-term services and supports) 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 donation sites.

- Understands basic issues related to different populations served, e.g., older adults, people with physical disabilities, intellectual/developmental disabilities, behavioral health-related needs, brain injury, Alzheimer's disease, or other cognitive differences and how these intersect with individual, cultural, linguistic, and other characteristics described in Competency A.
- 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. Supports building friendships and other meaningful connections outside the paid service system.
- Actively involves supporters, as directed by the person, in collaboratively developing and executing the person-centered plan in accordance with the preferences of the person.
- Supports the creation or maintenance of a meaningful life in the community (as defined by the person) as a fundamental human right rather than a privilege to earn by demonstration of "stability" or acts of compliance with professional recommendations.

C. Rights, Choice, and Control

Person-centered relationships and planning activities are based on respect and the presumption that people are competent to know what they like and have the right to control decisions that impact their lives. Practitioners support people in having control and discovering their voice in all aspects of plan co-creation, implementation, and review. Practitioners are aware of and able to educate people (when necessary and desired) about the range of legal protections that promote fundamental safety (e.g., the right to be free from abuse and neglect) and maximum community inclusion (e.g., the right to inclusive lifestyles, freedom from discrimination, and the right to exercise freedoms).

A facilitator competent in this domain:

- Presumes competence. All people are presumed to have the capacity, and the right, to actively participate in the planning process. This may require accessing supports that ensure the person's communication is welcome and respected.
- Understands the concepts of dignity of risk and the right to fail. Apart from some emergency situations, it 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.
- 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.
- 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.
- Practices supported decision-making, a series of relationships, interventions, arrangements, and agreements designed to assist a person to make and communicate decisions about their life to others, often around alternatives to guardianship and other legally sanctioned restrictions to freedom for people with disabilities.

- Understands how to recognize abuse, neglect, and exploitation, and the legal and administrative requirements related to the handling and reporting of such violations.
- Does not restrict access to common goods and services based solely on behavioral and treatment compliance. Decisions are made in collaboration with the person, balancing autonomy with personal and community safety.

D. Partnership, Teamwork, Communication and Facilitation

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

A facilitator competent in this domain:

- Attends to language and respects the preferences of the person. Understands the nuances behind person-first vs. identity-first language. Includes visualization tools when desired, such as charts and maps, to foster improved communication and dialogue.
- Solicits and 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).
- 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 prior to implementation and, on request, given a copy to review, edit, and suggest changes if it does not reflect their input.
- Makes space for the positive and respectful 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.
- 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 management and decision support.

- Maintains a focus in the conversation on the person's desired life goals and outcomes.
- Uses technology as needed (including telehealth and other virtual platforms) to maximize coordination, communication, and connections in the person-centered planning process.

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

A facilitator competent in this domain:

- Actively includes the person's strengths, interests, preferences, and talents in their plan and its implementation.
- Writes plans using the person's preferred name, language, and identity preferences throughout. Plans will be transcribed into an accessible format to ensure the person can easily access the plan throughout its development, implementation, and revision.
- Frames meaningful goal statements (i.e., the person's desired outcomes) using language that is clear and accessible while capturing what is important to the person in their own words wherever possible.
- 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.
- Solicits ongoing feedback from the person and their supporters on progress and concerns and revises the plan in an expedient manner, as desired by the person, using the same processes described in other competencies when needed.
- 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 Person-Centered Planning Monitoring:** Align quality improvement and monitoring tools with the 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 and provide constructive feedback to those involved.
    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 by using 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 adherence to person-centered planning leads to the achievement of the personally valued goals and meaningful life *outcomes* desired by people receiving services. A variety of positive outcomes-based measures should be used, including personal experience indicators, meaningful changes in schedules, personal accomplishments, increases in support circles, etc.
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 through ongoing support and supervision in meeting these expectations.

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

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

d) Educate and empower people and their loved ones so they are fully informed as to what they should expect in a quality person-centered planning process. Provide an outlet for complaints and resolution.

e) 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 universities, and human service certification programs.

Concluding Thoughts & Future Discussion

This resource was created for the purpose of defining essential skills and abilities to effectively facilitate person-centered planning in support of, and alongside, people receiving services. The focus on facilitator competencies across five primary domains should not interpreted as suggestion that person-centered planning 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 that there is any single "right" way to do person-centered planning 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 with services and supports. 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 outcomes?

And is it possible that high-quality person-centered planning and facilitation can lead not only to desired outcomes for persons served but also to fiscal savings and systemic efficiency on the part of the systems that serve or support 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 of disability must be engaged as partners in all aspects of the transformation process in order to realize person-centered planning at its full potential.

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

About This Document

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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 No Wrong Door 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 planning 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 Description[,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]
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]

*Access tools 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