# Community Navigator Service for Person Centered Planning

June 2018

# What are the Core Functions of a Community Navigator?

- Community Navigators' promote self-determination
- Community Navigators' also support each individual to ensure their true desires and needs are discovered and reflected in both the Individual Service Plan (ISP) and integrated into their supports.

(How does the Community Navigator ensure desires and needs are reflected in integrated supports? What does this look like?)

Core functions are implemented with the expected outcome of promoting self-determination

- Build relationships
- Problem solve
- Help locate resources
- Serve as a link between community, health, and social services (multidisciplinary teams)
- Advocate

# What are the Core Functions of a Community Navigator?

# Community Navigator and Clinical Coverage Policy 8P

- **Community Navigator Services can be provided to:**
  - **Encourage exploration of possibilities related to life goals, defining what those are and the steps that they need to take in order to have those met.**
    - **Support an individual to make decisions that are important to them.**
      - **Promote choice making to support the individual's strengths and interests.**

# Community Navigator and Clinical Coverage Policy 8P

- Provide education on decision making, risk taking, and natural consequences.
- Provide education which guides the individual in problem solving, decision making, and navigating multiple state systems.
- Promote advocacy and collaboration with other individuals and organizations on behalf of the individual
- Guidance with managing their individual budget.

# Community Navigator and Clinical Coverage Policy 8P

**-The functions described in bullets above support the following task:**

- **Supporting the person in preparing, participating in and implementing plans of any type (IEP, ISP, or service plans outside of NC Innovations)**

https://dma.ncdhhs.gov/behavioral-health-clinical-coverage-policies

# Community Navigator and Clinical Coverage Policy 8P

**-Another function of Community Navigator Services is noted in the Clinical Coverage Policy:**

- **Supports the person in the person centered planning process (i.e. development of Essential Lifestyle Plan (ELP), Making Action Plans (MAPS), Circles, etc.)**

**Community Navigator Services can support a person in the development of a person-centered plan that can be used to inform the service plan.**

https://dma.ncdhhs.gov/behavioral-health-clinical-coverage-policies

# Person Centered Planning And Service Planning

# Person Centered Planning A Closer Look: It Really Is All About Me!

- **Person-centered planning supports people with disabilities to express their needs, wishes, and goals with methods that reflect their individual culture and communication style.**
- **Person centered planning helps to generate opportunities for social inclusion through inclusion and participation.**

# Person Centered Planning

- **The person-centered planning viewpoint seeks to listen, discover and understand the individual. It is a process directed by the person that helps others to learn how they want to live and describes what supports are needed to help them move toward a life they consider meaningful and productive.**
- **The person centered planning process empowers the person by building on their individual abilities and skills, building a quality lifestyle that supports the person in finding ways to better themselves and contribute to their community.**

# Person Centered Planning: What's the focus?

- **Person Centered Planning focuses on the person and the outcomes that matter to the person.**
- **Outcomes are not goals; they determine whether the person's goals are achieved, looking beyond the implementation of the plan and in its place looking at the results.**
- **(https://c-q-l.org/resource-library/resource-library/all-resources/person-centered-outcomes-not-outputs).**

# Person Centered Planning: What's the focus?

- **Person Centered Planning- Changes the typical "service view" and assist others who both know and support the person to re-frame their views and perspectives of the person.**
- **Person Centered Planning helps the person's team see the person as full of potential.**

# Service Planning

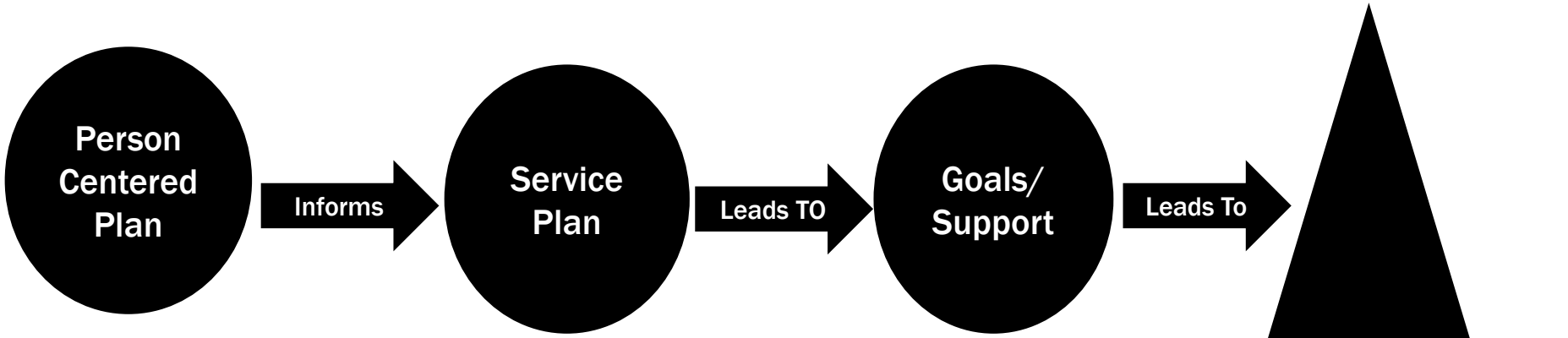
# Service Planning – The Action Steps Behind My Success

- **Service planning supports individuals with disabilities to acquire services through the ISP process.**
- **Service planning typically looks at measurable goals in yearly increments.**
- **Service planning pairs goals with services, which enable paid staff to assist the person with meeting his/her short range goals.**

# Service Planning – Cont'd

- A written ISP is developed with each person, utilizing a Person Centered planning process that reflects the needs and preferences of the person
- ISP's draw upon diverse resources, mixing paid, natural (such as family, friends, and neighbors) and other non-paid supports, to best meet the goals set.
- Short-Range Goals, Agencies With Choice, and Employers of Record are required to develop and implement short-range goals prior to ISP implementation that will assist the individual in meeting his/her measurable goals.

# How Person Centered Planning and Service Planning Fit Together

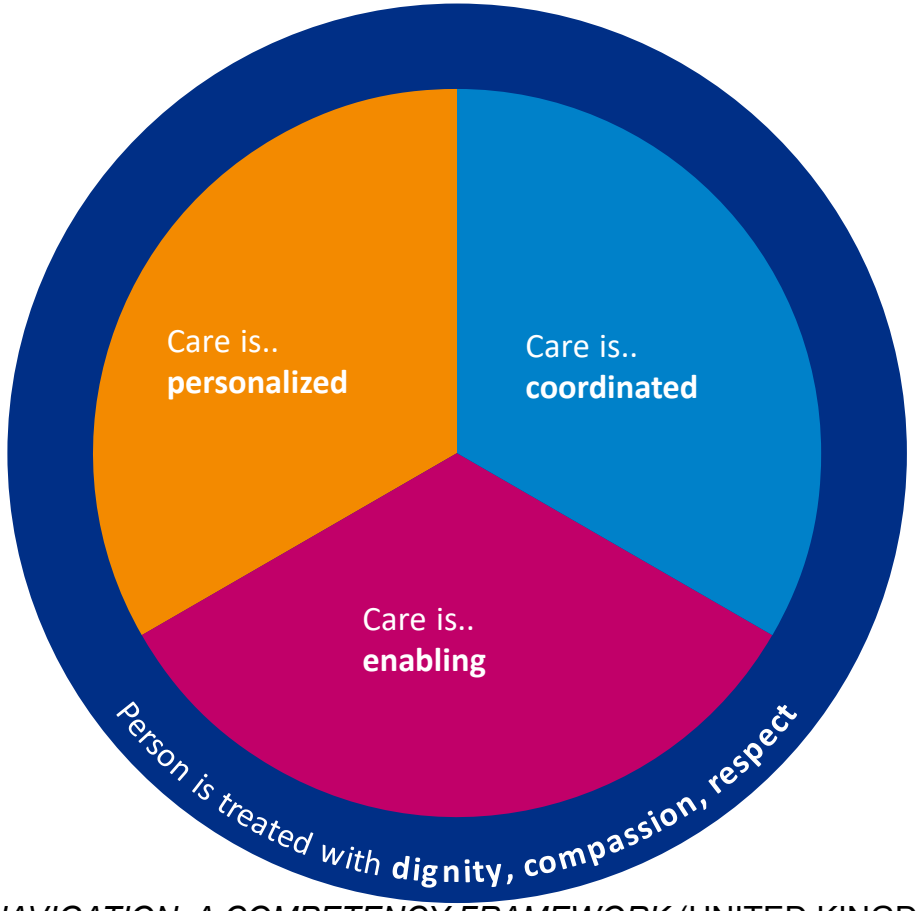



Long range outcomes, not necessarily Innovations specific

Yearly chunks, typically focused on Innovations scope or linking to other services and supports

# Community Navigator's Role in Person Centered Planning and Service Planning

# What is the Community Navigator's Role in Person Centered Planning?




SIMMS, J. (N.D.). *CARE NAVIGATION: A COMPETENCY FRAMEWORK* (UNITED KINGDOM, HEALTH EDUCATION ENGLAND, DEVELOPING PEOPLE FOR HEALTH AND HEALTHCARE). THE NHS CONSTITUTION.

# Community Navigator Role in Person Centered Planning

- **Enable individuals by supporting them to build on their capabilities**
- **Offering personalized care by focusing on what matters to the individual**
- **Offering coordinated care by assisting the individual to express their goals within a multidisciplinary team**

# What is the Community Navigator's Role in Person Centered Planning?

## The GROW Model

- **G**oal
  - What do you want?
- **R**eality
  - Current situation?
- **O**ptions
  - What could you do?
- **W**ill
  - What will you do?


- Recycle to achieve your goal

Grow Model | Sir John Whitmore's Grow Coaching Model Framework
https://www.performanceconsultants.com/grow-model

# Community Navigator Role in Person Centered Planning

- Use the ISP to identify outcomes
- Define the goals as long term (long term goal can be implemented in yearly chunks) or short term
- Identifying Goals
- Where is the Reality of the goal (where are we now in the goal process)?
- What Options are available?
- What Will the Individual do to reach the outcome (what is the plan action to complete the goals and reach the outcome)?

Grow Model | Sir John Whitmore's Grow Coaching Model Framework
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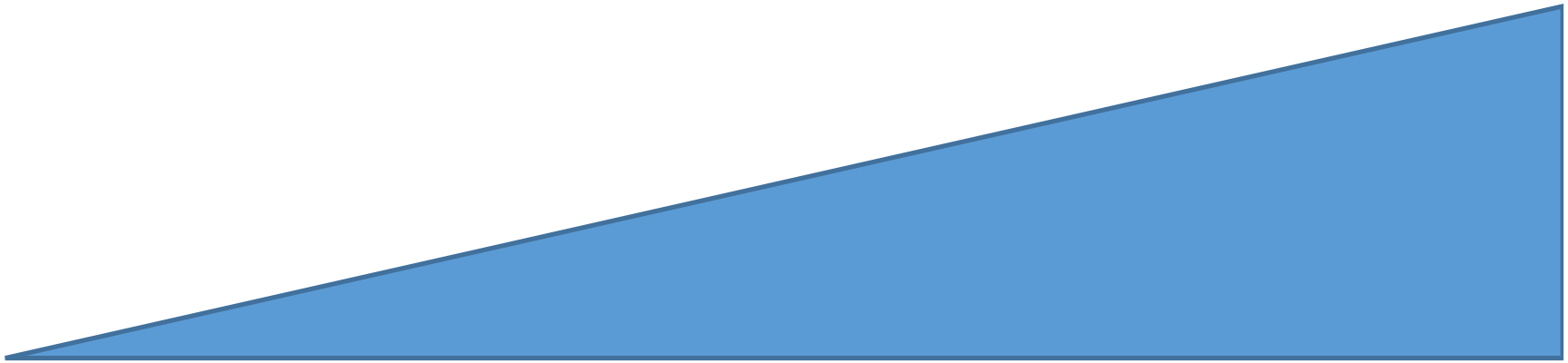
# Community Navigator and Clinical Coverage Policy 8P

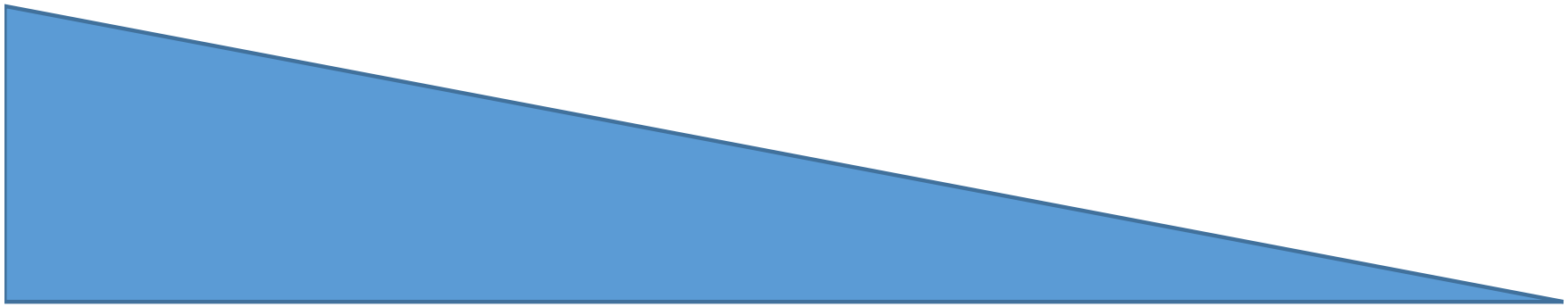
Community Navigator Service role can be a building up of a process to increase self-advocacy and support for self-determination.



Identifying life goals → Supporting decision-making and choice-making → Providing education and advocacy → Guidance with service budget → Support during service planning

# Community Navigator and Clinical Coverage Policy 8P

The Community Navigator Service can also be a more concentrated effort to develop a person-centered plan using a recognized person-centered planning tool.



The development of a PCP → Informs the service plan, natural supports, life goals.

# Person Centered Planning Tools

Person tools commonly organize and elicit a person's desires.

Some examples of Person Centered Tools are:

- Essential Lifestyle Planning (ELP): Focuses on what is "important to" and "important for" a person to achieve life goals http://www.learningcommunity.us/elp3.html
- MAPS (Making Action Plans): Creates an individual's story and charts action for the future. www.inclusion.com/maps.html
- PATH (Planning Alternative Tomorrows with Hope): Defines the future life that a person desires and the path to get there. www.inclusion.com/path.html
- Circles of Support: Identifies the people in a person's life that surround and support them in different ways toward their goals. www.inclusion.com/circlesoffriends.html

# Care Coordination/Community Navigator Timelines

# Community Navigator and Care Coordinator Timelines

- **Months Six, Seven and Eight Before Planning Meeting**

| Timeframe | Care Coordination Activities | Community Navigator Activities* |
|---|---|---|
| **8 months prior to planning meeting**<br>- 10 months prior to member's birth month<br>- 11 months prior to the start of the next plan year | • Begin monitoring and oversight of services<br>• If a SIS® Assessment is due for completion, this should be scheduled and completed during this timeframe | |
| **7 months prior to planning meeting**<br>- 9 months prior to member's birth month<br>- 10 months prior to the start of the next plan year | • If a SIS® Assessment is due for completion, this should be scheduled and completed during this timeframe | |
| **6 months prior to planning meeting**<br>- 8 months prior to member's birth month<br>- 9 months prior to the start of the next plan year | • If a SIS® Assessment is due for completion, this should be scheduled and completed during this timeframe | • Build a relationship with the member<br>• Educate the member about the steps of the planning process<br>• Identify who the member wants to include in the planning meeting (identify the planning team) |

# Community Navigator and Care Coordinator Timelines

- **Four and Five Months Before Planning Meeting**

| Timeframe | Care Coordination Activities | Community Navigator Activities* |
|---|---|---|
| **5 months prior to planning meeting**<br>- 7 months prior to member's birth month<br>- 8 months prior to the start of the next plan year | • If a SIS® Assessment is due for completion, this should be scheduled and completed during this timeframe | • Build a relationship with the member<br>• Educate the member about the steps of the planning process<br>• Identify who the member wants to include in the planning meeting (identify the planning team) |
| **4 months prior to planning meeting**<br>- 6 months prior to member's birth month<br>- 7 months prior to the start of the next plan year | • If a SIS® Assessment is due for completion, this should be scheduled and completed during this timeframe<br>• Explain the background of self-direction and self-determination | • Build a relationship with the member<br>• Educate the member about the steps of the planning process<br>• Identify who the member wants to include in the planning meeting (identify the planning team)<br>• Choose person-centered planning tools (ELP, MAP, etc.) and determine who will complete them<br>• Consider interest inventories |

# Community Navigator and Care Coordinator Timelines

- **Two and Three Months Before Planning Meeting**

| | | |
|---|---|---|
| **3 months prior to planning meeting**<br>- 5 months prior to member's birth month<br>- 6 months prior to the start of the next plan year | • Completion of Community Navigator Needs Assessment (if no Community Navigator is in place) and review utilization of services compared to the existing plan | • Identify whether the member wants to lead the ISP planning process<br>• Choose the type of plan template to use (color, black and white, minimalist<br>• Consider the use of pictures, videos, etc.<br>• Initiate person-centered planning tools (ELP, MAP, etc.)<br>• Initiate interest inventories |
| **2 months prior to planning meeting**<br>- 4 months prior to member's birth month<br>- 5 months prior to the start of the next plan year | • Completion of Risk Support Needs Assessment<br>• Conference call or meeting with the planning team (the family, providers, and anyone else the family wants present) to discuss the array of services that will go into the draft plan for the next plan year | • Choose the type of plan template to use (color, black and white, minimalist)<br>• Consider the use of pictures, videos, etc.<br>• Complete person-centered planning tools (ELP, MAP, etc.)<br>• Complete interest inventories |

# Community Navigator and Care Coordinator Timelines

- **One Month Before Planning Meeting**

| Timeframe | Care Coordination Activities | Community Navigator Activities* |
|---|---|---|
| **1 months prior to planning meeting**<br>- 3 months prior to member's birth month<br>- 4 months prior to the start of the next plan year | • It is appropriate to follow up with the family, and as part of routine monitoring, verify that what was discussed during the conference call is still the plan; or, if anything has changed, that that is incorporated into the draft plan | • Provide information to the Care Coordinator to complete the ISP<br>• Notify Care Coordinator of any technology needed during the planning meeting (e.g., to display PowerPoint presentation, pictures, etc.) |

# Questions