CARE PLAN FACILITATOR ROLE

To help achieve the most optimal results in the care planning process, we encourage one person, the Care Plan Process Facilitator (CPPF), assume many of the care planning responsibilities that are often spread amongst team members. It is not intended to be a new dedicated staff position. In addition, having one person lead the effort of person-centered care planning may become so valuable for the care and support of residents and for your team that you may choose to implement this role more formally. The CPPF will provide the key to assuring three critical aspects of an effective person-centered care planning process—1) development of a person-centered care plan that identifies and meets the clinical needs and what matters most for each person; 2) effective implementation of the plan and identification of triggers to revise the plan; and 3) assurance of constant quality improvement in each home's care planning process.

The CPPF is primarily an educator, coach, and contact for the resident whose job it is to *facilitate learning for*:

1. the interdisciplinary team as it develops living care plans that are centered in the strengths and needs of each resident
2. staff members with responsibility for implementing the plan
3. the continuous improvement in the overall capability of the home as it relates to the care planning process.

The CPPF will provide education to the residents, their family members, and the members of the staff team on all levels and in all departments to ensure a person-centered, clinically appropriate, empowering and regenerative care planning process occurs for each person. The home's expertise at successful implementation of the process becomes deeply embedded in the home's culture.

The person serving as CPPF will be a member of the interdisciplinary team and can come from any discipline or department, including direct care partners. They will facilitate learning in specific situations of planning and implementation and organization wide learning. They will be responsible for the multidisciplinary team's learning to increase its capacity to involve each resident along with their essential supports and representatives in the process so the team will better know and respond to the clinical, and psycho-social-spiritual needs of each resident. It is important to note that these may be new ideas or a new way of thinking about the existing care planning process, and there may be a need to reorganize the existing staff time being dedicated to care planning.