# Person-Centered Planning Guidelines for People Living in the Community

**Texas Health and Human Services**

**Intellectual and Developmental Disability Services**

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# Purpose and Definitions for Person-Centered Planning Guidelines

## Purpose

Reflecting the national trends in the way services are delivered to people with developmental disabilities, the Texas Health and Human Services Commission (HHSC) implemented person-centered planning. The purpose of this document is to provide direction to people with intellectual and developmental disabilities (IDD), their families, professionals, service providers, and local intellectual and developmental disability authorities (LIDDAs) in the development of effective person-directed plans (PDPs). This planning process will be used to develop services and supports for people with IDD receiving community services. Person-centered planning is consistent with the recent emphasis in Texas on self-determination and the achievement of personal outcomes for people with IDD in Texas.

It can be said that person-centered planning is based on **four core values: respect of self-determination, dignity, community inclusion,** and **optimism and belief.**

**Respect of Self-Determination**

- Self-determination means respecting the life choices and decisions a person makes based on preferences and interests with a focus on the whole person, not just on physical and mental disability.
- Choice and personal control are central to creating quality in the person's life. Person-centered planning supports the person to have positive control over their life choices.

**Dignity**

- This is the right of a person to be treated with respect and as a valued member of their community, as afforded to any person in the larger community.
- The person is recognized as having capacity to exercise their rights unless limited by law or court order.

**Community Inclusion**

- Community inclusion means all people, regardless of their abilities, disabilities, or health care needs, have the right to be included and appreciated as valuable members of their communities, like all others.
- The Council on Quality and Leadership (CQL) states that quality of life definitions should be driven by life expectations common to everyone in society regardless of their labels or need for extra support.

**Optimism and Belief**

- Optimism is the belief that each person has the potential for a great life.
- Belief is trusting that each person can contribute to society in a meaningful way.

While HHSC does not require the use of a specific person-centered planning process, it does require that the elements listed below be evidenced in the planning process developed by LIDDAs. This document describes the definitions, discovery process, action planning process, and monitoring process necessary in a person-centered system that will satisfy the required elements. There are a number of processes and products (books, videos, etc.) available on the topic of types of person-centered planning which are listed in the last section of this document (Resources on Person-Centered Planning and Other Related Topics**)**.

# Definitions

- **Discovery process:** The process of identifying the strengths, preferences, and desires of the person that provides the foundation for developing the PDP.
- **Individual:** A person in the LIDDA priority population, as defined under 26 Texas Administrative Code (TAC) Section 304.102, seeking or receiving services. An individual is referred to as the **person** in this document.
- **LAR (legally authorized representative):** Someone authorized by law to act on behalf of the person and who may include a parent, guardian, or managing conservator of a child, or a guardian of an adult.
- **Natural supports:** Supports that occur naturally and voluntarily within the person’s environment. These are not paid supports or those purposely developed by a person or system. Some examples of natural supports are family members, church, neighbors, and friends.

- **Needs:** What the person must have in order to ensure their safety, health, and successful integration into the community. Needs are often what is "important for" the person as found in assessments.
- **Open-ended questions:** Questions that allow for more than just a one- or two-word response.
- **Outcome:** What is important to the person to do, achieve, change, maintain, or experience.
- **Person-centered planning:**
    - is a process by which a person, with assistance (if needed, or if the person has a legally authorized representative), identifies and documents their preferences, strengths, and needs in order to develop short-term objectives and action steps which ensure personal outcomes are achieved in the most integrated setting by using identified supports and services.
    - is an approach that helps create a vision for a person's life based on life choices to include their social role, dreams and inclusion in the community.
    - identifies and highlights a person's unique talents, gifts, and capabilities.
    - organizes around the person to help put into place paid, unpaid, and natural supports and resources that will assist him or her in achieving personal outcomes. Person-centered planning prioritizes what is "important to" a person as well as what is "important for" a person.

      In summary, person-centered planning is a process to help people identify their strengths, preferences, and needs (clinical and support); achieve personally defined outcomes in the most integrated setting; and ensure delivery of services in manner that reflects personal choices, dreams, and life aspirations.
- **Person-centered thinking:** The philosophical foundation of person-centered planning. It is the core belief about a person's inherent value and the way to think about and discover a person's unique preferences and personal life outcomes.
- **Preference:** A choice a person makes for one option over others. For instance, people have preferences on where they would like to work, eat, live and whom to live with.

- **Service coordinator:** An employee of the LIDDA who provides assistance in accessing medical, social, educational, and other appropriate services that will help the person achieve a quality of life and community participation acceptable to the person (and LAR on the person's behalf) as follows:
    - crisis prevention and management – locating and coordinating services and supports to prevent or manage a crisis;
    - monitoring – ensuring that the person receives needed services, evaluating the effectiveness and adequacy of services, and determining if identified outcomes are meeting the person's needs and desires as indicated by the person (and LAR on the person's behalf);
    - assessment – identifying the nature of the presenting problem and the service and support needs of the person; and
    - service planning and coordination – identifying, arranging, advocating, collaborating with other agencies, and linking for the delivery of outcome-focused services and supports that address the person's needs and desires as indicated by the person (and the LAR on the person's behalf).
- **Services:** Any programmatic or professional resources recommended in assessments which are available to anyone within the community and used to meet personal outcomes.
- **Strengths:** Qualities, traits, talents, or abilities that a person has demonstrated in the past.
- **Supports:** Any form of paid, unpaid, or natural assistance available to a person and any other member of the community.

# Person and LIDDA Indicators for Person-Centered Planning

This section summarizes the person and LIDDA indicators of successful implementation of person-centered planning. The following elements provide information to guide practitioners in the field (e.g. service coordinators) in facilitating a high quality PDP.

## Indicators for the Person

- Evidence that information was provided to the person and LAR to allow the person to make informed choices/decisions.
- Evidence that the person determines their preferences during the person-centered planning process together with their family/LAR and friends.
- Evidence that the person chose whether other people should be involved and identified the people to be included in the person-centered planning process.
- Evidence that the person chose the time and location of the person-centered planning session.
- Evidence that the person chose their outcomes and support staff whenever possible.
- Evidence that the person's preferences and outcomes were seriously considered and in situations where it is difficult to implement the team arrived at a compromise acceptable to all.
- Evidence exists that the service coordinator ensures that the plan remains current at all times.
- Evidence that the service coordinator ensures the plan is monitored on an ongoing basis for effectiveness in achieving the outcomes identified by the person with the support of their family/LAR. This is a critical element since a person's goals and preferences are constantly evolving. It is important to keep asking questions, listening, and discovering the preferences of the person.

# Indicators for LIDDA Staff

- The LIDDA has a clear plan which delineates how person-centered planning will be implemented throughout the agency.
- The LIDDA ensures that staff involved in administering, planning, delivering, and monitoring services and supports receive on-going training and mentoring in person-centered planning.
- The LIDDA makes every effort to utilize resources available to them in their community (e.g. volunteers, natural supports) when helping people and families achieve the person's outcomes.
- The LIDDA makes every attempt to develop a flexible system driven by the needs of the person and their families.
- The LIDDA's quality improvement plan actively seeks feedback from the person and their families regarding the opportunities they have to express needs and preferences and the ability to make choices.
- The priorities set by the LIDDA in its local plan are driven by the feedback provided by the person and their family members regarding the services and supports they receive within the broad framework provided by HHSC.
- The LIDDA has a clear plan which indicates how it will increase public awareness regarding person-centered planning.
- The LIDDA provides opportunities for the person and their families to learn about the philosophy and mechanics of the service delivery system.

# Guiding Principles for Person-Centered Planning

This section identifies elements that a service coordinator should consider when conducting person-centered planning meetings.

- Person-centered planning prioritizes what is **"important to"** a person as well as what is **"important for"** a person. Person-centered planning seeks a balance between "important to" and "important for" that is unique to the person. Important to, important for, and the balance between them is the core concept and foundation for Person-Centered Thinking (PCT), based on work by The Learning Community for Person Centered Practices (TLCPCP).
    - **Important TO:** Those things in life that contribute to the person's satisfaction, contentment, comfort, fulfillment, and happiness. Important-to includes what matters the most to the person, their own definition of quality of life. Important-to commonly involves:
        - ◊ People to be with/relationships
        - ◊ Culture and identity
        - ◊ Things to do and places to go
        - ◊ Rituals and routines
        - ◊ Purpose and meaning
        - ◊ Rhythm or pace of life
        - ◊ Status and control
        - ◊ Things to have
    - **Important FOR:** Those things that involve issues of health, safety, and value.
        - ◊ Issues of health:
            - Prevention of illness;
            - Treatment of illness/medical conditions; and
            - Promotion of wellness (e.g., diet and exercise).
        - ◊ Issues of safety:
            - Environment;
            - Well-being--physical and emotional; and
            - Freedom from fear.
        - ◊ What others see as necessary to help the person:
            - Be valued; and
            - Be a contributing member of their community.

- In person-centered service planning:
  - the person receiving services will lead the person-centered planning process, when possible; and
  - the person's LAR (if applicable) and team members have a participatory role, with planning driven by the person.

    **Note:** people with IDD who have court-appointed legal guardians participate in person-centered planning to the maximum extent possible and have the right to exercise full control of all aspects of life not specifically granted by the court to the guardian.
- The person’s differences and differences in family dynamics and composition are respected and accepted.
- Person-centered planning requires that it is the person who defines what is meaningful in their life.
- All people with IDD can make choices and contributions and need to exercise control of their lives. Sometimes in order to do this effectively they must be supported by others, either in their natural environment or from within the system. In the case of young children, their families and primary caregivers can make choices and contributions in the child’s life.
- There is choice among flexible, dependable services that meet each person’s immediate needs and support each person’s goals and aspirations for a lifestyle that affords personal control, informed decisions, dignity, and respect.
- Person-centered planning builds on the person’s strengths and contributions.
- Person-centered planning encourages the “growth of community” around the person and their families. It helps develop supports to facilitate relationships with people within the person’s community.
- The person should have full participation in all the decision-making activities that affect their lives.
- All issues that emerge during the person-centered planning process are negotiated to ensure that resulting activities are consistent with the person’s or family’s preferences and goals.
- As needed, the person, family, and support staff work in partnership to explore creative options to meet the preferences and goals expressed by the person or family.

- Resources authorized to support people are based on identified needs that the person may have and are available in the agency. These needs typically cannot be supported by the person’s natural supports. *To fill the gaps created by limited resources, generic resources presently available in the community are used to complement the agency resources. In instances where generic resources may not exist, they may need to be developed within the community*.
- All strategies and resources used must support the desired outcomes and identified needs of the person or family.
- The person or LAR must be informed that they may request a revision to the PDP at any time by communicating the request to the service coordinator or the program provider, if applicable. The PDP is also revised when significant changes occur in the person's life. It is a dynamic rather than a static process.
- The person’s or family’s cultural background is acknowledged and valued in the planning and decision-making process.
- Information is provided in plain language and in a manner that is accessible to people with disabilities and people who have limited English proficiency.

# Indicators of Effective Person-Centered Planning

## Discovering the Person

- **Listen, acknowledge, and discover the personal goals, preferences, choices, and abilities of the person directing the plan:**
  - A person-centered planning process must occur with the person present. If the person is a child and having the child present during the meeting becomes difficult, then meeting with them at a later time is essential to discovering their preferences and needs.
  - Before meeting with a group of people, the service coordinator goes over the issues to be discussed with the person and their LAR. They delineate those issues that will be discussed in a larger group (public issues) and those that are to be discussed more privately (private issues).
  - The service coordinator asks open-ended questions to elicit information from the person, family members, and primary caregiver in order to discover the preferences, choices, goals and abilities of the person.
  - The discovery process does not have to occur in a planning meeting with a large group of people. It can occur separately with the person or LAR and those who know the person well.
  - The discovery process solicits information based on the person's strengths, capacities, and contributions.
  - All the information collected from team members (outside of the person-centered planning meeting) during the discovery process must be confirmed with the person to ensure accuracy before documenting it.
  - Person-centered planning is an ongoing process and not a one-time/annual planning process. The person's goals and preferences are constantly evolving so it is important to keep asking questions, listening, and discovering the preferences of the person.

    - Ensure that the person and family receives information and support to make informed choices, including choosing services and alternative home and community-based settings.

- **Documentation of the information gathered during a person-centered planning process is important:**
    - All information should be written in a respectful manner.
    - Documenting the information gathered from the person or family is crucial to ensure that it is available to all pertinent staff (new and old). This ensures that the person and family members are not asked the same questions repeatedly by new staff.
    - All the information must be documented in the plan without changing the meaning that the person or family member attributes to it.
    - The documentation should cover the person's daily routines and desired goals. It should be descriptive, but concise, painting a picture of the person. Describing issues functionally provides a better picture of the person's need for support. For example, when documenting a behavior such as verbal or physical aggression, a description of how it manifests and the situations in which it occurs must be included. Merely stating that the person is verbally or physically aggressive may not provide sufficient information to determine the supports the person may need.
    - The PDP must include information relevant to any issues concerning the person's health and safety. Supports to maintain the person's health and safety should be developed within the context of their preferred lifestyle so that it does not conflict with their preferences.
- **The person or LAR determines who is involved in the planning process:**
    - The person or LAR chooses the members of the service planning team. The team may include family members, friends, and paid staff.
    - The team members must respect, trust, and support the person.
    - If bringing together a team for the planning process is difficult, then developing one should become a priority. However, the planning process can be initiated while the team is being developed.
    - The team members meet in a comfortable location, as defined by the person. This may help the person feel relaxed and open enough to share things that are important to them with the rest of the team.

- **Identify the existing services and supports (natural or paid), both used and unused, that are consistent with the person or family achieving identified goals:**
    - In most situations, the person, their family members, and friends have the most knowledge about the preferences, capacities, and contributions of the person and themselves, while professionals have knowledge of resources available in order to provide appropriate supports and treatments. All members should play an active and collaborative role in order for the planning process to be effective.
    - The person, their family members, and professionals recognize and document in the plan the existing supports in the person's life.
    - Previously unexplored natural supports in the community are discovered during the process.
    - Identified supports match the preferences of the person or family.
    - The planning process considers the supports that the person may require for issues that may not be directly related to the outcome but influence the strategies and actions that are developed to achieve the outcome.
- **Other professionals (not originally included by the person in their planning team) are identified as consultants, when needed:**
    - All professional consultations, such as a nurse or psychologist, occur in the presence, or with the permission, of the person or LAR and are conducted in a manner respectful to the person.
    - The person, family, and professionals are encouraged to have a trusting and collaborative relationship.
- **Issues of safety, health, rights, and freedom from abuse and neglect are dealt with in the PDP:**
    - The planning process includes a discussion of individualized health and safety issues in the context of the life desired by the person. The process maintains a respectful balance between rights (choice/control), responsibilities, and risks (health/safety), as experienced by all citizens.

# Action Plan

- **To identify additional natural supports and negotiate needed service supports:**

- Negotiate both natural and service supports to develop the best possible support plan to achieve what is important to the person.
- The person or family determine their own supports by participating in selecting, evaluating, and when necessary, changing their support staff.
- The person-centered planning team members identify opportunities to connect the person and the family to their community.
- The person or family is supported to develop community connections.

- **Implementation of the support strategies becomes the responsibility of the planning participants:**
  - The plan of action includes:
    - ◊ goals and strategies,
    - ◊ person(s) responsible for the completion of the goal and strategy, and
    - ◊ any pertinent information related to achieving the goal or strategy.

    (**Note:** Including specific names of people facilitating the monitoring process.)
  - The goals and aspirations are prioritized by the person or family.
  - The most important goals and aspirations are addressed first.
  - A plan is more easily implemented if the team works on a few goals and aspirations at a time.
  - Preferences should not be considered to be the same as services and supports. Services and supports are used to facilitate the acquisition of the person's preferences. For example, the person may express a preference to work in a bank. However, he or she may require the support of a job coach to achieve the desired goal. The support of a job coach is not the expressed preference of the person in this case. The job coach is the support needed to achieve a goal based on the expressed preference.
  - In a case in which there is a disagreement between the person and their LAR, every effort should be made to negotiate and clarify conflicting issues. The service coordinator must keep the person's preferences and desires the main focus of the planning process and resolve the LAR's concerns to come up with the best compromise between the two.

- There must be a partnership between all the team members to implement the plan. No single team member should be responsible for its implementation.

- **When people choose outcomes that conflict with state or program guidelines, the following strategies should be considered to meet the person's needs:**
  - Identifying goals or needs that can be achieved within the existing standards, rules and regulations within the HHSC system, while problem solving on how to accomplish the ones that are more difficult to achieve.
  - Explore resources in other systems and programs serving people with disabilities and services available to all citizens, whether or not they have a disability, in the community to fulfill these needs.
  - Use the existing system to its fullest potential and negotiate to create the best possible arrangement for the person or family.
  - Discover why a particular choice or the refusal of an alternative presented in place of the original choice is important to the person.

## Monitoring the Quality of the Person-Centered Planning Process

The quality of a person-centered planning process is defined by the person or family and is reflected in more personal outcomes being achieved. There will be a multi-level monitoring process to ensure the quality of PDPs:

- The service coordinator renews the plan prior to expiring, periodically monitors the services the person receives to achieve their desired outcomes, and revises the plan as needed.
- A review by the local management structure and its local quality improvement process.

# Resources on Person-Centered Planning and Other Related Topics

## The Learning Community for Person Centered Practices

### Person-Centered Thinking

For people being supported by services, it is not person-centered planning that matters as much as the pervasive presence of person-centered thinking. If people who use services are to have positive control over their lives, if they are to have self-directed lives within their own communities, then those who are around the person - especially those who do the day-to-day work - need to have person centered thinking skills. Only a small percentage of people need to know how to write good person-centered plans, but everyone involved needs to have good skills in person centered thinking, in the value-based skills that underlie the planning.

There are a number of reasons for this. Teaching and supporting the use of person centered thinking skills will mean that:

- It is more likely that plans will be used and acted on, that the lives of people who use services will improve
- You will have a number of ways to get plans started
- Updating the plans will occur “naturally,” needing less effort and time

Every style of person centered planning is rooted in a person centered way of thinking. It is made up of a set of value-based skills that result in seeing the person differently and give us a way of acting on what is learned. Training in person centered planning is training in a way of thinking as much as it is in a way of developing a plan. In essential lifestyle planning we have identified basic skills and tools that help learners understand and embrace this way of thinking.

Person Centered Thinking

## Person Centered Thinking (PCT) Trainers

Search for a PCT trainer:
Trainer Directory Search

## Person-Centered Practices

Person-Centered Practices - YouTube

# Council on Quality and Leadership (CQL)

CQL works to improve the quality of life for people with intellectual, developmental, and psychiatric disabilities.

CQL | The Council on Quality and Leadership

# National Center on Advancing Person-Centered Practices and Systems (NCAPPS)

NCAPPS is an initiative from the Administration for Community Living and the Centers for Medicare & Medicaid Services that helps States, Tribes, and Territories implement person-centered thinking, planning, and practice in line with U.S. Department of Health and Human Services policy. Resources available on this webpage include:

- Five Competency Domains for Person-Centered Planning; and
- Using NCAPPS Resources to Support Compliance with the HCBS Final Rule Requirements for Person-Centered Planning webinar.

NCAPPS | National Center on Advancing Person-Centered Practices and Systems

# Person-Centered Texas Administrative Code (TAC) References

- 26 TAC Section 262.201
- 26 TAC Section 262.701(g)(2)
- 26 TAC Section 263.201
- 26 TAC Section 263.901(b)(2)
- 26 TAC Section 331.19(b)(2)