**PERSON CENTERED CARE PLANNING**

**Guiding Principles for Person Directed Planning:**

1. Individual differences and differences in family dynamics and composition are respected and accepted.

2. Person directed planning requires that it is the individual who defines what is meaningful in their life.

3. All individuals 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.

4. There is choice among flexible, dependable services that meet each individual’s immediate needs and support each individual’s goals and aspirations for a lifestyle that affords personal control, informed decisions, dignity, and respect.

5. Person directed planning builds on an individual’s strengths and contributions.

6. Person directed plans encourage the “growth of community” around individuals and families. It helps develop supports to facilitate relationships with people within the individual’s community.

7. Individuals should have full participation in all the decision-making activities that affect their lives.

8. All issues that emerge during a person or family directed plan are negotiated to ensure that resulting activities are consistent with the individual’s or family’s preferences and goals.

9. As needed, the individual, family, and support staff work in partnership to explore creative options to meet the preferences and goals expressed by the individual or family.

10. Resources authorized to support individuals are based on identified needs that the focus person may have and are available in the agency. These needs typically cannot be supported by the individual’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*.

11. All strategies and resources used must support the desired outcomes and identified needs of the individual or family.

12. The person directed plan is revised when significant changes occur in an individual's or family’s life (or needs). It is a dynamic rather than a static process.

13. A person’s or family’s cultural background is acknowledged and valued in the planning and decision-making process.

**What Must Be In a Person-Centered Plan?**

The final CMS Home and Community Based Services (HCBS) rule provides requirements for person-centered planning. HHS is educating people on person-centered planning and initiating changes in processes and systems to ensure that the planning process meets the [HCBS settings rule.](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=6130f5a18988ee77d60504f3d88ed72a&mc=true&n=pt42.4.441&r=PART&ty=HTML#se42.4.441_1725)

This process will take a few years to fully implement. In the meantime, HHS is implementing policies to ensure the person-centered planning process will be:

* Driven by the person getting services and reflective of his or her perspective.
* Made up of people the client chooses.
* Conducted at a time and place convenient to the person getting services.

The plan must be reviewed and revised annually with a functional needs assessment, when circumstances or needs change, or when the client asks for a review.

Certain elements have to be included in each plan.

* It must be written using plain language.
* It must consider the person’s cultural preferences.
* It has to include strategies for solving disagreements during the planning process.
* It must provide choice regarding services and providers.
* It must have a way for clients to request an update.
* It must include risk factors and mitigation strategies.
* It must be signed, with copies given to the person getting services and her or his representatives.

The final service plan must reflect:

* The client's choice of setting and how that setting is integrated in and supports access to the community.
* Opportunities to seek competitive employment and work in integrated settings.
* Ways to engage in community life, control personal resources and receive services in the community to the same degree of access as people not receiving HCBS.
* The client's strengths and preferences.
* Clinical and support needs.
* Goals and desired outcomes, as defined by the person getting services.
* Services that will be provided, including self-directed services.
* Who will provide services and supports, including unpaid natural supports, such as family and friends.

**Resources**

* [HCBS Settings Rule PowerPoint Presentation (PDF)](https://www.medicaid.gov/medicaid/hcbs/downloads/final-rule-slides-01292014.pdf)
* [Community First Choice Rule in the Texas Administrative Code](http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=T&app=9&p_dir=N&p_rloc=177897&p_tloc=&p_ploc=1&pg=8&p_tac=&ti=1&pt=15&ch=354&rl=1360)
* [Community First Choice Webinar FAQs and Webinars (PDF)](https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/hcbs/20160725-person-centered-planning.pdf)
* [List of approved trainings](https://hhs.texas.gov/services/disability/person-centered-planning/waiver-program-providers/person-centered-planning-pcp-training-providers)
* [Minimum requirements for training content](https://hhs.texas.gov/services/disability/person-centered-planning/waiver-program-providers/minimum-requirements-pcp-training)
* [HHS Brand Guide (PDF)](https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/vendor-contract-information/hhs-brand-guide.pdf)

**Questions?**

Questions can be sent to [PersonCenteredPlanning@hhsc.state.tx.us](mailto:PersonCenteredPlanning@hhsc.state.tx.us).