Summary of HHS Guidance on Person Centered Planning

The guidance defines person-centered planning (PCP) as a process "directed by the person with LTSS needs. It may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. PCP should also include family members, legal guardians, friends, caregivers, and others the person or his/her representative wishes to include. The PCP approach "identifies the person's strengths, goals, preferences, needs (medical and HCBS), and desired outcomes." The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires. The guidance describes "process elements" for PCP, including:

1. The person or representative must have control over who is included in the planning process, as well as the authority to request meetings and revise the plan.
2. The process must be timely and occur at times and locations of convenience to the person.
3. Necessary information and support must be provided to ensure the person and/or representative is central to the process, and understands the information.
4. A strengths-based approach to identifying the positive attributes of the person must be used.
5. Personal preferences must be used to develop goals, and to meet the person's HCBS needs.
6. The person's cultural preferences must be acknowledged.
7. The PCP process must provide meaningful access to participants and/or their representatives with limited English proficiency.
8. People under guardianship or other legal assignment of individual rights should have the opportunity in the PCP process to address any concerns.
9. There must be mechanisms for solving conflict or disagreement within the process.
10. People must be offered information on the full range of HCBS available to support achievement of personally identified goals.
11. The person or representative must be central in determining what available HCBS are appropriate and will be used.
12. The person must be able to choose between providers or provider entities when choice is available.
13. The PCP must be reviewed at least every twelve months or sooner.
14. PCP should not be constrained by any pre-conceived limits on the person's ability to make choices.
15. Employment and housing in integrated settings must be explored.

The guidance also indicates that the PCP must have the following attributes:

1. It must reflect that the setting where the person resides is chosen by the individual. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving HCBS.
2. The plan must be prepared in person-first singular language and be understandable by the person and/or representative.
3. The positive attributes of the person must be considered and documented at the beginning of the plan.
4. The plan must identify risks, while considering the person's right to assume some degree of personal risk, and include measures available to reduce risks or identify alternate ways to achieve personal goals.
5. Goals must be documented in the person's and/or representative's own words, with clarity regarding the amount, duration, and scope of HCBS that will be provided to assist the person.
6. The plan must describe the services and supports that will be necessary.
7. The specific person or persons, and/or provider agency or other entity providing services and supports must be documented.
8. The plan must assure the health and safety of the person.
9. Non-paid supports and items needed to achieve the goals must be documented.
10. The plan must include the signatures of everyone with responsibility for its implementation including the person and/or representative, his or her case manager, the support broker/agent (where applicable), and a timeline for review.
11. Any effort to restrict the right of a person to realize preferences or goals must be justified by a specific and individualized assessed safety need and documented in the PCP.
12. The plan must identify the person(s) and/or entity responsible for monitoring its implementation.
13. The plan must identify needed services, and prevent unnecessary or inappropriate services and supports.
14. An emergency back-up plan must be documented that encompasses a range of circumstances (e.g. weather, housing, staff).
15. The plan must address elements of Self-Direction (e.g. fiscal intermediary, support broker/agent, alternative services) whenever a self-directed service delivery system is chosen.
16. All persons directly involved in the planning process must receive a copy of the plan or portion of the plan.

Implementing the person-centered plan "requires monitoring progress to achieve identified goals," including "mechanisms to ensure all HCBS - paid and unpaid - are delivered, that the plan is reviewed according to the established timeline; there is a feedback mechanism for the person or representative to report on progress, issues and problems; and that changes can be made in an expedient manner." People receiving HCBS must be fully involved in the process to update their service plans. Successful implementation "for systems or accountable entities" requires "policy, mission/vision

statements, and operations documents at the federal, state, local, and person-level (for self-direction) aligned to incorporate PCP standards." A process for monitoring PCP "should be implemented at the federal, state, and local levels and incorporated as an integral component of quality improvement activities across HCBS programs."