

Person-Centered Planning Walk-Through

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Content

Person-Centered Planning Walk-Through

Resource type: Tier 1 Flagship — Methodology / Framework

Adapted from: O'Brien & Lyle (1987); Smull & Harrison (1992); CMS HCBS Settings Rule (2014); Minnesota Statutes §256B.0659; DHS DSD Practice Standards

Library home: L07 Disability Services Practice Library

Companion to: T04_08 Supported Decision-Making; T04_09 LifeCourse Framework; T04_06 SAMHSA TIP

What this framework is

Person-centered planning (PCP) is both a philosophy and a structured process for developing service plans that genuinely reflect what matters to the person — their goals, preferences, relationships, and definition of a good life — rather than what a professional determines is best for them. PCP emerged from the independent living movement and early disability rights advocacy in the 1970s and 1980s, was formalized through the work of John O'Brien, Beth Mount, Michael Smull, and others, and is now required by federal law for all individuals receiving Home and Community-Based Services (HCBS) funded by Medicaid.

The philosophical core of PCP is straightforward and radical: the person with a disability is the primary authority on their own life. Their preferences, goals, and choices are not one input among many; they are the organizing center of the plan. Everything else — professional expertise, family input, service availability, regulatory requirements — is in service of that center.

Person-centered planning is legally required under the Centers for Medicare & Medicaid Services (CMS) HCBS Settings Rule (42 CFR §441.301), which DSD services are subject to. It is embedded in Minnesota Statutes governing DSD service programs. It is not optional and it is not aspirational; it is a regulatory floor with real enforcement implications.

Why DSD uses this framework

DSD serves people with disabilities who have historically experienced services designed around the priorities of systems, institutions, and professionals rather than around themselves. The history of

disability services in the United States includes forced institutionalization, involuntary sterilization, guardianship without consent, and service systems in which people with disabilities had minimal voice in decisions that shaped every dimension of their lives.

Person-centered planning is DSD's structural commitment to a different paradigm: a paradigm in which the person's own vision of a good life is the starting point, and DSD's role is to support — not to determine — how that vision is pursued.

PCP also has practical service-quality benefits: research consistently shows that services designed around individuals' actual preferences and goals produce better outcomes, higher satisfaction, and better quality of life than services designed around professional or organizational defaults.

The core concepts (plain language with citations)

Important TO vs. Important FOR

The most foundational conceptual distinction in person-centered planning is between what is important TO a person and what is important FOR a person.

Important TO is what the person cares about — what gives their life meaning, pleasure, purpose, and connection. This is their answer, not yours. Important TO includes relationships, activities, rhythms, places, sensory experiences, creative expression, cultural and spiritual practices, and anything else that matters to the person as they define their own life.

Important FOR is what is necessary for the person's health, safety, and wellbeing — what they need in terms of support, medical care, safety monitoring, and skill development. Important FOR is often where professional expertise contributes.

VCU's DSP Orientation resource (<https://dsporientation.partnership.vcu.edu/section-i/the-value-of-person-centered-planning/>) describes this distinction as essential to PCP: "Person-centered planning promotes the value that the wishes of a person are to be honored, based on what he/she considers important to them."

The tension in services — and the most common site of PCP failure — is when "important FOR" concerns (safety, health, compliance) override "important TO" priorities so thoroughly that the person's own goals disappear from the plan. Trauma-informed practice (T04_06) and supported decision-making (T04_08) both reinforce that risk is not an automatic override of preference: people have the right to make choices that carry risk, and DSD's role is to inform and support, not to control.

What makes planning genuinely person-centered

AxisCare's guide (<https://axiscare.com/tip-sheets/person-centered-plans-for-idd-importance/>) and VCU's DSP Orientation (<https://dsporientation.partnership.vcu.edu/section-i/the-value-of-person-centered-planning/>) identify several conditions that distinguish genuine PCP from plan-writing that uses the

language but not the substance:

1. The person is the starting point, not the system. Planning begins with who the person is, what they care about, and what kind of life they want — not with available services, professional assessments, or eligibility categories.
2. The person drives the process. The person chooses who is at the planning meeting. They shape the agenda. Their communication style — not the meeting's default format — organizes how information is gathered and shared.
3. The people who know and love the person are included. PCP is not an individual assessment process; it is a community-building process. The person's network of relationships — family, friends, neighbors, community members — is an asset, not a complication.
4. Plans reflect actual preferences, not professional defaults. A person-centered plan looks different from person to person because people are different. A plan that looks identical to every other plan in the caseload is not person-centered.
5. Plans address barriers, not just needs. PCP includes identifying what stands between the person and the life they want — and naming concrete steps to address those barriers. "Barriers to full inclusion" is a PCP required element, not a philosophical nicety.
6. Plans are living documents. PCP is not an annual event; it is a continuous process of learning, adjusting, and deepening understanding of the person. What was true a year ago may not be true today.

The DSP role in person-centered planning

Direct Support Professionals are often the people who know the individuals they support best — because they spend the most time with them, in the most intimate contexts of daily life. This makes DSPs essential contributors to genuine PCP.

Elegant Care Villa's guide (<https://elegantcarevilla.org/careblog/the-importance-of-person-centered-planning-to-an-individual/>) describes the DSP role: "Getting to know the individual plays a vital role in person-centered planning... The DSP best positioned to get this information." DSPs' observations — what a person responds to with joy, what they avoid, what communication styles work, what doesn't — are primary PCP data. These observations should be documented, shared in planning meetings, and treated as evidence of what matters to the person, not dismissed as anecdotal.

DSPs are also the people most responsible for implementing person-centered plans in daily life — translating plan language into daily practice that actually reflects the person's preferences. Implementation fidelity is where PCP most often fails; a person-centered plan that exists on paper but is implemented through institutional defaults is not person-centered in practice.

Legal and regulatory context

Person-centered planning is required in DSD services under:

- CMS HCBS Settings Rule (42 CFR §441.301): Requires that all HCBS-funded services use person-centered planning processes, and that services are delivered in integrated community settings that support individual choice, autonomy, and dignity. The rule explicitly requires that services optimize "individual initiative, autonomy, and independence in making life choices, including in daily activities, physical environment, and personal associations." See NJ DDD HCBS Settings Rule Guide. (<https://nj.gov/humanservices/ddd/assets/documents/providers/DDD-Provider-Guide-to-HCBS-Settings-Rule-Final.pdf>)
- Minnesota Statutes: Minnesota law governing DSD programs explicitly requires person-centered service planning for individuals receiving waiver and other DSD-funded services.
- The Olmstead Decision (527 U.S. 581, 1999): The Supreme Court's Olmstead decision requires states to serve people with disabilities in the most integrated setting appropriate to their needs. Person-centered planning is the mechanism through which "most integrated setting appropriate to their needs" is determined — by the person, not the system.

What it looks like in DSD practice

Before the planning meeting:

A case manager preparing for an annual planning meeting contacts the person three weeks in advance to ask: "Who do you want to have at your meeting? Where would you like to have it? What's on your mind that you most want to talk about?" The person chooses their own apartment. They invite their mother, their neighbor, and a friend from their day program. The case manager prepares by reviewing the DSP's observations and notes from the past year, not just the prior year's plan.

During the planning meeting:

The meeting begins with the case manager asking the person: "Tell me about a really good day you had this past year — what made it good?" The conversation that follows produces more usable plan content than an hour of professional assessment. The family and friends contribute stories and observations. The case manager asks the DSP: "What have you noticed this year that you think is important for us to know?" The plan that emerges looks different from last year's because the person has changed.

Addressing "important TO vs. important FOR" tension:

A person with complex medical needs wants to attend their church community every week. The case manager has concerns about transportation and health monitoring. A person-centered approach does not resolve this by removing church attendance from the plan; it identifies what supports are needed to make church attendance possible, and whether the health concerns can be addressed in ways that preserve the person's choice rather than eliminate it.

Implementation in daily support:

A DSP knows from the person's plan that they like to sleep until 9 a.m. and eat breakfast before getting dressed. The group home's morning routine schedule was written for a different person who no longer lives there. The DSP advocates with their supervisor to update the morning schedule to reflect the current residents' actual preferences — not the house default.

How to apply this in your role

As a DSP:

- Document what you observe about what the person enjoys, avoids, and responds to — systematically, not only when something goes wrong.
- Bring your direct knowledge to planning meetings. You often know the most about what is "important TO" the person.
- When you notice a practice that contradicts what the plan says matters to the person, name it and escalate through appropriate channels.

As a case manager or service coordinator:

- Ask "important TO vs. important FOR" questions in every planning interaction.
- Structure planning meetings around the person's voice, not the form's fields.
- Check implementation fidelity: does the plan reflect what the person said they wanted, and does daily support reflect the plan?

As a supervisor or program manager:

- Ensure planning processes provide sufficient time and structure for genuine person-centered engagement — not just documentation completion.
- Review plans for evidence of the person's voice, not just compliance with required elements.

Common misconceptions

"We use person-centered language in our plans, so we're person-centered." Language without process and implementation is not PCP. The question is whether the person's voice actually drove what's in the plan, and whether the plan is actually implemented in daily practice.

"Person-centered planning means the person can do anything they want." PCP includes honest discussion of health and safety needs ("important FOR"). The key is that those needs are addressed in ways that preserve the person's goals and choices, not ways that replace them.

"If a person can't communicate verbally, person-centered planning doesn't apply." PCP applies to every person, regardless of communication modality. DSPs, family members, and others who know the person well can provide evidence of preferences through careful, systematic observation of behavior and response.

"The annual plan meeting is person-centered planning." The annual meeting is one event in a continuous process. Person-centered practice happens in every daily support interaction, every decision made on behalf of the person, every conversation about their life.

Connection to other frameworks

- Supported Decision-Making (T04_08): SDM is the legal and ethical framework for how people with

disabilities make their own decisions. PCP is the planning process that reflects those decisions. They are inseparable.

- LifeCourse Framework (T04_09): LifeCourse's life domains provide a comprehensive map for PCP to ensure that "important TO" is explored across all dimensions of life, not just service dimensions.
- Trauma-Informed Practice (T04_06): PCP's empowerment and choice principles directly align with TIP's empowerment principle. TIP enriches PCP by adding explicit attention to safety, trust, and the conditions under which genuine choice is possible.
- Cultural Humility (T04_04): "What matters to this person" cannot be understood without cultural humility — including humility about what "independence," "good life," and "appropriate support" mean across cultural contexts.
- Berry Acculturation (T04_10): For people from non-dominant cultural backgrounds, PCP must be attentive to acculturation dynamics: what does community integration mean in this person's cultural context? What relationships and cultural practices are essential to this person's "important TO"?

Connection to DSD's six program goals

DSD Goal — PCP Connection

Goal 1 — Eliminate Disparities — Person-centered plans that are genuinely shaped by the person's cultural values and priorities — not just professional defaults — are a mechanism for reducing disparate outcomes.

Goal 2 — Community Engagement — Genuine community integration — the core Olmstead and HCBS commitment — is only achieved when the person's own definition of "community" shapes the plan.

Goal 3 — Hiring and Retention — Staff who experience their work as genuinely person-centered — actually serving people's real goals — are more likely to find their work meaningful and stay.

Goal 4 — Learning and Development — PCP skills — listening, observation, facilitation, cultural humility — are core competencies for DSD staff at every level.

Goal 5 — Contracts and Procurement — DSD's contracted providers are required to deliver person-centered services. PCP fidelity is a contract performance standard.

Goal 6 — Communication and Accessibility — Person-centered communication requires accessibility: using the communication modalities and formats that work for the person, not those that are easiest for the staff member.

When to escalate / where to refer

- If a person's stated preferences conflict with family or guardian preferences: Consult with your supervisor and the person's legal representative. Refer to supported decision-making guidance (T04_08). The person's voice is primary where they retain decision-making capacity.
- If implementation of a person-centered plan is being overridden by facility or program practices: Escalate to your supervisor and program manager. This is a regulatory compliance concern under the HCBS Settings Rule.
- For tools and templates: The LifeCourse framework's Charting the LifeCourse (<https://www.lifecoursetools.com>) tools provide practical PCP support materials. Contact the One DSD Resource Hub for DSD-specific resources.

Reflective questions for your practice

1. The last plan you wrote or reviewed: whose voice is most present in the goal language? The person's, or the professional's?
2. What would change about how your team runs planning meetings if the person actually set the agenda?
3. When did you last ask someone "What was a really good day for you this year?" and use the answer to shape a plan?
4. Where in your service context do "important FOR" concerns routinely override "important TO" preferences? Is that override justified by evidence, or by professional habit?
5. If the person you serve most recently described their own life to you, would their description match the goals in their current service plan?

Sources

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- Elegant Care Villa. (2025). The Importance of Person-Centered Planning to an Individual. <https://elegantcarevilla.org/careblog/the-importance-of-person-centered-planning-to-an-individual>
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Always defer to the person in front of you. Frameworks describe patterns; people are individuals.

Document what you observe about what the person enjoys, avoids, and responds to — systematically, not only when something goes wrong.

Ask "important TO vs. important FOR" questions in every planning interaction.

Check implementation fidelity: does the plan reflect what the person said they wanted, and does daily support reflect the plan?

Ensure planning processes provide sufficient time and structure for genuine person-centered engagement — not just documentation completion.

Review plans for evidence of the person's voice, not just compliance with required elements.

Ask: What would change about how your team runs planning meetings if the person actually set the agenda?

Ask: When did you last ask someone "What was a really good day for you this year?" and use the answer to shape a plan?

For policy regulatory analysts, use Person-Centered Planning Walk-Through to connect the guidance to the person's goals, program rules, access needs, and follow-up; trace each recommendation to current authority, preserve exceptions, and document the decision record. Start by document what you observe about what the person enjoys, avoids, and responds to — systematically, not only when something goes wrong.

For program service staff, use Person-Centered Planning Walk-Through to verify current authority, preserve rights and exceptions, and route interpretation questions; apply the guidance in the person-specific workflow, explain options accessibly, and document the next step. Start by ask "important TO vs. important FOR" questions in every planning interaction.

For facilitators learning leads, use Person-Centered Planning Walk-Through to connect the guidance to the person's goals, program rules, access needs, and follow-up; build the guidance into preparation, practice, debrief, access checks, and follow-up. Start by check implementation fidelity: does the plan reflect what the person said they wanted, and does daily support reflect the plan?

Do not replace official legal, policy, clinical, supervisory, program, or Tribal authority.

Do not infer an individual's identity, preferences, needs, or experience from group-level information.

State uncertainty, use current authoritative sources, and escalate when the decision exceeds the user's role.

Person-centered planning (PCP) is both a philosophy and a structured process for developing service plans that genuinely reflect what matters to the person — their goals, preferences, relationships, and definition of a good life — rather than what a professional determines is best for them. Step 1. Document what you observe about what the person enjoys, avoids, and responds to — systematically, not only when something goes wrong. Step 2. Ask "important TO vs. important FOR" questions in every planning interaction. Step 3. Check implementation fidelity: does the plan reflect what the person said they wanted, and does daily support reflect the plan? Step 4. Ensure planning processes provide sufficient time and structure for genuine person-centered engagement — not just documentation completion. Step 5. Review plans for evidence of the person's voice, not just compliance with required elements. Step 6. Ask: What would change about how your team runs planning meetings if the person actually set the agenda? Step 7. Ask: When did you last ask someone "What was a really good day for you this year?" and use the answer to shape a plan?