NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Person-Centered Planning and Practice Committee Web Meeting 6

The National Quality Forum (NQF) convened the Person-Centered Planning and Practice Committee for a web meeting on January 6, 2020.

Welcome and Review of Web Meeting Objectives

Co-chairs Gretchen Napier and Cheryl Phillips introduced themselves and welcomed the Committee members, liaisons, and general public.

Kate Buchanan, NQF Senior Project Manager, welcomed the Committee and reviewed the meeting objectives:

- Introduce a PCP framework approach, development process, and draft measurement framework.
- Committee members and liaisons to provide feedback on the draft measurement framework.

Quality Measure Overview

Sam Stolpe, NQF Senior Director, began with an overview of healthcare quality measures. The Committee was introduced to concepts on how quality measures are used to quantify the cost and quality of care provided to persons and their families as well as general concepts of how to gauge the quality of care for the purposes of improving how care is provided. The Committee reviewed typical data sources for informing metrics, typical entities that are measured, and applications for measurement for internal quality improvement, benchmarking, and accountability. An overview was given of an example measure with which most Committee members are familiar—the CAHPS HCBS measure.

Recap of Measure Environmental Scan

Dr. Stolpe reviewed with the Committee the results of the environmental scan conducted by NQF staff over the summer of 2019. This scan for existing person-centered quality and efficiency measures informed several objectives of the project:

- Framework of PCP measure development
- Research agenda for PCP
- Identification of gaps in quality and efficiency measures available
- Identification of priorities to advance or address measurement gaps

Dr. Stolpe clarified the difference between measure concepts and fully developed quality measures, and the role of NQF in endorsement. The scan revealed 366 unique measures and measure concepts, but none directly connected to person-centered planning. Relevant measures were assigned to categories of patient experience, frequency, complex care, care transitions, communication, and shared decision making.

The Committee noted the three data sources used for the environmental scan: NQF's Quality Positioning System, CMS' Measure Inventory Tool, and CMS' Qualified Clinical Data Registry measure inventory. The

Committee suggested that NQF also review the measure concepts proffered in the 2016 NQF HCBS final report.

PCP Framework Approach

Dr. Stolpe initiated this section with an overview and definition of a measure framework. Three domains of a prospective PCP Framework were defined:

- Person- centered plan measures
- PCP facilitator measures
- System-level measures

Dr. Stolpe reviewed examples of measures that could potentially be categorized into each of these domains. The Committee co-chairs then led a discussion with the Committee to further populate the domains with measure ideas that would be important for person-centered planning.

Person-Centered Plan Measures

Initial ideas from staff included:

- Measures of whether a person-centered plan is in place
- Measures on the content of the plan
- Person-reported outcome measures

Ms. Napier led a discussion with the Committee on measures to supplement the initial examples offered by staff. These included:

- Individuals feel they know their rights
- Barriers were identified (systematic or family)
- Plan reviews goals of person each time
- Plan was based on the person's choice
- Content of the plan: plan is written in the person's own words
- Goals include a diversity of desired outcomes
- Preplanning—way to get information to individuals about the planning to make them prepared
- Conversation about lookback: what was the last year like, and how have goals changed?
- Was the person able to access the plan?
- PRO—was it updated according to the person's time?
    - Was I treated with respect; did people listen to me?
    - Did I have decision making authority?
    - Evidence that dignity of risk is addressed in the plan
    - Did you feel prepared to come to your person-centered planning meeting?
    - Did you feel that the people of the room were able to determine if requests within the plan could be implemented?
    - Are the outcomes my outcomes and are they being acted on?

PCP Facilitator Measures

Dr. Stolpe reviewed the two suggested examples of PCP facilitator measures, namely that persons have planning options that include receiving language services, screening for preferred spoken language, hearing tools, and other communication tools; and that measurable competencies identified in the PCP core competencies are captured, such as PCP training completion, knowledge of PCP principles, cultural competency, resource knowledge, and policy and regulation knowledge.

Dr. Phillips then led the group in a discussion to identify additional measures. The Committee noted the following measurement ideas:

- Frequency of updates to the measures
    - Timely assessment and update
    - Timely sharing and review
- Plan produced within the timeframe required
- Person-centeredness training
- Knowledge of HIPAA and HITECH
- Knowledge of nonmedical transportation
- Humility and respect
- Knowledge of disabilities and health conditions with persons they are working with
- Tracking what happens after a plan is in place
- Person's overall satisfaction with the facilitator

System-Level Measures

Dr. Stolpe outlined three measure types that could be included in the system level measure domain: structure, process, and outcome measures. Ms. Napier then led a discussion that identified potential measures for inclusion in the framework. The Committee offered the following ideas:

- Number of PCP participants per facilitator
- Percentage of trained staff
- Barriers were addressed
- Issues that needed follow-up were addressed
- Resource allocation
- PCP quality improvement participation

Public Comment

Public comments fell within several different themes. Appendix A provides a full list of all public comments received. Here is a summary.

- Measures within the framework need to focus on outcomes, and how the person-centered plan helped the individual achieve the life they want.
- Most of the people we plan with will have plans updated for decades. Updating plans is also the facilitator's role and requires facilitating and incorporating ongoing learning.
- The public warned about the need for balance; measures that were meaningful to people with person-centered plans but were not overly burdensome to report.
- Recommended measures that strengthen systems' understanding and use of accessibility, technology, and access.
- Need to consider measures that assess the individual's experience and/or the legal representative.
- It is very important for the individual to assess the effectiveness of the facilitator.
- The public recommended that measures focus on the independence of facilitators who should be independent, if possible.

Next Steps

Yvonne Kalumo-Banda, NQF Project Manager, shared that the Committee recommendations and public comments will be considered when finalizing the draft measurement framework.

The Committee, liaisons, and the public were advised to send all project-related correspondence, inquiries, and resources to pcplanning@qualityforum.org or call 202-783-1300.

The next Committee meeting was announced for February 3, 2020 from 12:30 pm to 3:00 pm ET, when the Committee will review the updated draft measurement framework and provide input on the PCP research agenda. It was noted that the final draft report will be posted for a 30-day public commenting period from April 8 to May 8, 2020. The final draft report will include all components of the draft interim report which will be updated per feedback received from the interim report public comment: the definition of PCP; set of core competencies of people performing PCP facilitation; recommendations to HHS for systems characteristics that support person-centered thinking, planning, and practice and the framework for PCP measure development; research agenda for PCP; and environmental scan.

The public was encouraged to subscribe to project alerts to keep track of meeting dates and meeting resources as they are posted onto the project webpage.

Appendix A: Public Comments Submitted Through Chat

Sender	Message
Susan Fegen	Don't know if she heard me. I am on.
Denise Myler	Denise: I am here. I will call in so I can make comments.
Nicole Leblanc	Medicaid claims data?
Rose Warman	Slides are behind the speaker
Rose Warman	Reloading browser worked ... TY
Amber Decker	Slide 7 Question Can we define what we mean by? Iimprovement activities?? Slide 10 Questions: What are the other reasons that we measure other than the Primary goal? Comments: We should include maintenance versus only to improve health and wellbeing. We need and should include other reasons besides the Primary goal for why we measure.
Nicole Leblanc	It would be good to have measures on Social Determinants of Health, address Health Disparities among I/DD population
Amber Decker	Slide 11 Questions: The question of where do data for measures come from limits us to only seven bullets where did we get these from? As far as Electronic assessment data goes why did we select the Minimum Data Set (MDS) and Outcome and Assessment Information Set (OASIS)? Comments: Both of these Electronic assessments and data are targeted uniform instruments to assess nursing home residents and or adult home care patients, this leaves out a host of other populations. Perhaps the problem is that data for measures does not and has not come directly from: individuals, families and community-based organizations, social service and human service sectors Slide 12 Comment: Leaves out the what is being measured. Slide 19 Comment: Qualified Clinical Data Registries should not be included as they lack a significant number of search terms that the committee has found relevant
Nicole Leblanc	We need a national movement to declare PWD a Medically Under-served Population
Amber Decker	Can you please explain why Access and Utilization of LTSS and HCBS are not considered as measures?

Sender	Message
Alan Rozen	Support Amber's comments on expanding purpose, utilization and value of metrics. For example, measurements can also standardize the effectiveness of involved processes
Fred Romero	Are we speaking about general health performance measurements or specifically the measurement of person-centered practices? If the latter, I agree with Pat that the measures should address the holistic quality of life of the individual; not just their health?
Fred Romero	i.e. PC focuses on the complete individual not just the disability, etc.
Nicole Leblanc	States also gather data via their Quality Service Reviews of Developmental Disability Providers
Nicole Leblanc	Ex number of folks with an annual physical
Nicole Leblanc	Special Olympics also collect data on health of adults with I/DD
Nicole Leblanc	Measure if they had annual dental checkup since we know many folks with I/DD get limited to poor dental care
Nicole Leblanc	Does a person have access to physical activity or a local gym to maintain health and wellness
Alan Rozen	For example, are these PCP plans reviewed and approved by THAT individual or their appropriately designated representative? To whom have these developed PCP plans been shared? Recognizing and measuring outcomes from these initiatives will be affected by knowing the extent to which PCP plans initiatives are developed, disseminated and utilized across providers, settings and circumstances.
Nicole Leblanc	Measure access to healthy food and nutrition education as a measure?
Sara Link	No Wrong Door systems have been working to establish measures. These are some that Virginia has looked at specific to HCBS and LTSS.
Sara Link	Several of the discussion points from the subcommittee findings were: Support individuals in the environment of their choice in the way that they prefer? Demonstrate that we are supporting more people in the community in order to continue and build funding? Outcomes ? Quantitative? Are we providing sufficient options for an individual to make a choice? Are we supporting more individuals in the community/their environment of choice? Can we show the delivery of more service with less cost Outcomes? Qualitative? Are individuals maximizing their autonomy? Are individuals feeling like they have choices and that they understand them? Are we successfully supporting families and entire households comprehensively NWD Outcomes? Early intervention and prevention? Eligibility was determined faster? Support options before Medicaid spend-down occurs? Support options before increased rates of re-hospitalization Conclusion The sooner a person is connected to needed supports, the greater the likelihood of diverting or avoiding decline, complications, the need for additional supports and institutional (facility and/or acute) care.

Sender	Message
Nicole Leblanc	access to support and aides that relieve pain of support folks in healing from trauma
Amber Decker	Slide: 25 Framework Domains for PCP Person-Centered Plan Measures PCP Facilitator Measures (Includes the person-centered planning process) System Level Measures Comment Consider adding Consumer control, i.e. self-direction and self-determination Access to LTSS and HCBS Number of Population Health who are using LTSS and HCBS living outside of Institutional settings successfully
Amber Decker	Slide 26: Comment: While this is supposed to be Person-Centered Plan Measures the majority seem to still fall under a system level measures (i.e. Plan in Place, Documentation of a plan, Updating of plan, Plan assessment during care transitions, Content of the plan) We are leaving out accessibility of and to a plan, and planning tools, Individuals rights to a plan
Amber Decker	Can we consider just the creation of a goal? Activity?
Amber Decker	Slide 27 PCP Facilitator Measures Comment: Missing Knowledge of the Individual Missing PCP Core Competencies Missing process elements and experts Missing content elements and experts Missing a definition of a PCP Facilitator
Amber Decker	Slide 28 Comment: Missing: Individual Access to the Plan or planning process and tools Accessibility of the plan
Amber Decker	Correction Slide 28 Comment: Missing: Individual Access to the Plan or planning process and tools Accessibility of the plan Comment: Missing Number of staff to person ratio

Sender	Message
Amber Decker	Slide: 29 Asks: Are the three domains reflective of the Committees preferences to how to approach a measure framework? Comment We still need to address if Person Centered Planning is a service or not. We have left out of our discussion and approach the individual, access to services and utilization numbers of LTSS and HCBS currently What are the most important things to measure within each of the domains? If I have to Choose one would choose the System Level Measures and Person-Centered Plan Measures as they seem to be the most important, individuals often have no choice but to rely on Systems in order to access LTSS and HCBS
Sally Burton-Hoyle	Where is the indicator of a pre-plan for the plan?
Alan Rozen	I highly suggest including an initial measure of not just completing (or even starting a plan) but a metric on documenting when that the plan has been verified (I.e., acknowledged) by that individual. Plans developed under PCPP risk becoming INEFFECTIVE or else limit opportunities for improvement if they do NOT get appropriately disseminated, referenced, utilized or updated.
Nicole Leblanc	Ideas for Domains, Access to healthy food, exercise, annual physical, health promotion events, activities that are accessible to all people with I/DD
Amber Decker	Slide 26 comment: Timing of the Plan "Was the Plan Produced, implemented in a timely fashion?
Nicole Leblanc	Provider agencies who offer HCBS should have funding to cover gym memberships as a way to promote exercise
Amber Decker	Sorry I mean Slide 26 (Time) What is the time frame 30 Days 60 days? 12 months?
Sara Link	Some questions we ask:
Alan Rozen	Clarification: An ideal practice would be documenting the DATES, TIMES and SPECIFIC SECTIONS when a plan is modified.
Sally Burton-Hoyle	In Michigan's Mental Health Code, the plan must be initiated and in process within 30 days of eligibility.
Sara Link	Were you able to make an informed decision based on the information you received?
Sara Link	Did you learn about community options you were not aware of before working with us?
Sara Link	Were you linked with services in a timely manner?
Nicole Leblanc	Plan should be written in accessible manner
Sara Link	Were your opinions and perspective respected?
Nicole Leblanc	People should choose their goals not just have others impose them
Amber Carey-Navarrete	I agree that measuring the timeliness of the plan and plan review is important. I am wondering if it is more of a System Level Measure than a PC Plan Measures.
Nicole Leblanc	They should have access to someone who can go over the plan in an accessible manner, ensure comprehension of stuff

Sender	Message
Nicole Leblanc	Go over your successes and challenges from previous year,
Nicole Leblanc	It should be in variety of formats, large print, paper copy, etc
Amber Carey-Navarrete	I also agree with the importance of pre-planning. Possibly measures finding out if the person felt prepared for their planning meetings would be helpful.
Mia Phifer	Additional measures to consider:
Nicole Leblanc	Having the ability to move around your budget when needed
Michael Michael	Plans only matter if they are implemented. Both the quality of the plan and the quality of the implementation need to be measured
Sally Burton-Hoyle	Can we stop using the word patient?
Amber Decker	Slide 26: Missing Person with Decision making authority
Amber Decker	Slide 26: Missing Person with Decision making authority to provide access to LTSS and HCBS
Amber Decker	Correction Slide 26: Missing Person with Decision making authority to provide access to LTSS and HCBS
Mia Phifer	care plan includes services important to individual, timely comprehensive assessment and update; timely comprehensive care plan and update; care plan communicated timely; care plan includes services and supports that reflects individuals' goals.
Nicole Leblanc	Agree 110% Case managers need better training on person centeredness
Amber Decker	Slide 26 Were Due Process Rights Provided to the Person/Family/Guardian?
Nicole Leblanc	Not have Power of the person
Sara Link	Should the measure read person/individual reported versus "patient" reported? Patient implies clinical and medical setting.
Alan Rozen	Consider how any comparisons of potential outcomes will require validation of their prevalence in an understandable context. As per my written feedback in advance of Web Meeting #5, measuring when a plan has been confirmed or its association whenever? there is a significant change in a persons' location, setting, health status, treatment(s), caregiver(s), provider(s), family members, personal preferences, needs or concerns.?
Laura Demeuse	that's where pre-planning comes in!! (the person who can say yes)
Laura Demeuse	Pre-planning should identify a general idea of person's choices and preferences, what they would like to do/try... this way someone who can say yes can be prepared and at the meeting.
Amber Decker	Slide 27
Amber Decker	Slide 27 PCP Facilitator Measures Comment: Missing Knowledge of the Individual Missing PCP Core Competencies Missing process elements and experts Missing content elements and experts Missing a definition of a PCP Facilitator
Amber Decker	Knowledge of Health Insurance Portability and Accountability Act (HIPAA) and The Health Information Technology for Economic and Clinical Health (HITECH) Act

Sender	Message
Bevin Bevin	would it make sense to draw from the extensive list of staff competencies to develop PCP facilitator measures?
Alan Rozen	As potential Facilitator and System measures, tracking what happens AFTER a plan is in place will be essential!
Amber Decker	Slide 27 Time of Response/Follow up to The Person, and Number of PCP Participants per Facilitator
Mia Phifer	Consider "overall satisfaction with facilitator" measure
Michael Michael	Somewhere in all of this we should note that 1st plans take more time but only need to be done once. Most of the people we are planning with will have plans updated for decades. Updating plans is also the facilitators role and requires facilitating and incorporating ongoing learning
Angela Martin	Facilitators should be independent, if possible. CMS is directing HCBS services to include conflict-free case management and supports coordination. Independent facilitation moves HCBS services and supports towards this expectation.
Amber Decker	Consider Person Centered Facilitation Measures
Susan Fegen	Many of the state HHS offices define the facilitator as the health plan representative who is responsible for ensure there is a plan in place.

Sender	Message
Sally Burton-Hoyle	INDEPENDENT FACILITATION: What's It All About? Michigan Developmental Disabilities Council What is independent facilitation? An Independent Facilitator is an individual who facilitates the Person-Centered Planning (PCP) process in collaboration with the person. In Michigan, individuals? receiving support through the Community Mental Health Service Provider (CMHSP) have a right to choose an independent or external facilitator for their PCP. The terms independent and external mean that the facilitator is independent of or external from the CMHSP. It means that the person has no financial interest in the outcome of the supports and services outlined in the PCP. CMHSPs are required to have contracts with enough independent facilitators to ensure availability and choice of people to meet their needs. Independent facilitators must not have any other role within the CMHSP. The Medicaid Provider Manual (MPM) permits billing for independent facilitation as one aspect of coverage called? Treatment Planning.? This is billed to Medicaid under code H0032. Using an independent facilitator is valuable in many different circumstances, not just when there is disagreement or conflict. You should you use an Independent Facilitator when: You want your needs and desires put forward by someone who doesn't decide what will be paid for? You are concerned that your plan will not become action? You need some changes in your life? You want control of planning your life. The role of the independent facilitator? Personally, know or get to know the individual who is the focus person of the planning? Help the person with all pre-planning activities and assist in inviting participants chosen by the person to the meeting(s)? Assist the person to choose planning tool(s) to use in the PCP process? Facilitate the PCP meeting(s), or support the individuals to facilitate his or her own PCP meeting(s)? Provide needed information and support to ensure that the person directs the process? Make sure the person is heard and understood? Keep the focus on the person? Develop a person-centered plan in partnership with the person that expresses the persons goals? Is written in a language understandable to the person? Provides for services and supports to help the person achieve their goals Who can be an Independent Facilitator? An advocate? Someone you trust? Someone who puts your needs FIRST? Someone other than your Case Manager, or Supports Coordinator? A member of your family. Any person you want, can choose to help you at no charge, or you can facilitate your own PCP. However, to be paid through Medicaid, the facilitator must be free of any financial interest in the outcome of the supports and services outlined in the PCP and be trained to be an Independent Facilitator
Angela Martin	I find it quite frustrating there is so much discussion to create a list of requirements, qualifications, and skills for facilitators when agency staff who are facilitating planning processes are NOT held to the same expectations. Degrees and credentials alone do not qualify a person high-quality, qualified planning facilitator.

Sender	Message
Amber Decker	Slide 28 Comment: Missing: Individual Access to the Plan or planning process and tools Accessibility of the plan Comment: Missing Number of staff to person ratio
Sally Burton-Hoyle	file:///C:/Users/sburtonh/Documents/pcp_524026_7.pdf
Michael Michael	Outcome measures for the person served/supported should come first
Amber Decker	Missing definition of participants, role of each participant in the plan
Amber Decker	Slide 28 Missing due process
Alan Rozen	With the approval of the involved individual (or legal representative), assessing a Facilitator and System by measuring the percentage of those participating entities who have reviewed an individual's plan will provide valuable insight. Moreover, as the definition and scope of quality? has been reframed by NQF and other entities, it will be important to remain consistent by acknowledging the multiple layers of possible LTSS? i.e., elements of Social Determinants of Health (SDOH) and allied services. So, consider measuring when that Facilitator and System acts on individuals? wishes to share their plans to THEIR designated appropriate community entities, not just clinicians.
Alan Rozen	Comments above parallel current speaker's comments on evolving communications beyond just clinicians and typical providers...
Amber Decker	Slide 28 Add Outcome Measures barriers, personal factors, needs, choice
Amber Decker	Sorry Choice available
Tammy Evrard	System level measures on allocation of resources are used to support the development, implementation, monitoring and reporting on person-centered practices.
Tammy Evrard	Measures that include developing partnerships, collaborations and alliances.
Amber Decker	Slide 28 Missing definition of participants, role of each participant in the plan centered plan and planning process
Michael Michael	The key questions are:
Michael Michael	Are the outcomes my outcomes and are they being acted on
Alan Rozen	To promote collaborations across NETWORKS of SYSTEMS, perhaps consider measuring WHICH types of entities consistently look for and review a PCP plan to reach broader communities
Tammy Evrard	Strengthen systems understanding and use of accessibility, technology, and access as a natural part of working collaboratively with others, not just as an accommodation.
Daniela Lawton	Will a recording of this meeting be available?
Chairperson	Yes, a recording will be posted on the project page by end next week.
Tammy Evrard	Need to focus on outcome on how the plan has helped the person achieve the life they want. The plan is important, but the end result is the action for the person to have a meaningful life.