NATIONAL QUALITY FORUM

Moderator: Benita Kornegay Henry
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7:38 am CT

Debjani Mukherjee: Good afternoon everybody. And good morning to those on the West Coast. Welcome to the Person Centered Planning and Practice Committee Web Meeting. This is the second meeting for this committee.

And I would like to take this opportunity to welcome all our committee members, and for all of them making time to participate today. And as well as, the NQF staff who have worked very hard in getting everything ready for this meeting.

My name is Debjani Mukherjee. I'm one of the SD's on this project, along with Sam Stolpe, my colleague, who's also another Senior Director. And with that I would like to turn it over to our Co-chairs, Gretchen and Cheryl, to say some welcoming words.

Cheryl Phillips: Thank you. Gretchen, you want to go first? This is Cheryl.

Gretchen Napier: Oh, thank you. I'm Gretchen and - Gretchen Napier, with TennCare in Tennessee. And I'm so glad that you all are joining us again. And I really am

excited about all the work that's gone on to get us here. And I'm looking forward to the conversation we're going to have today? Cheryl.

Cheryl Phillips: Yes, and thank you. Because last time I went first so, I thought it was only fair. Yes, welcome everybody to Committee. This is Cheryl Phillips. Both Gretchen and I have been reviewing all of the comments. I know that this is a very engaged group.

We'll be talking a little bit more about some of the process questions that have come up. But we are both enthused and positive about the level of engagement and the thoughtful comments that have been provided.

Our goal is to try to move through the comments as well as, the discussions on the slide today. And I know that the NQF Team will talk about some of the work steps. But I think we will have an opportunity to address what your concerns may be. So again, thank you. And I'm going to turn it back to NQF.

Kate Buchanan: And one of the things we've noticed, it sounds like there's some purring or some animal noises. Maybe a frog that's in the background. So if you could just make sure, if they are committee members, to please mute their lines if they're not currently speaking, that would be really beneficial.

To mute your line, please click star 6. And star 6 will mute your line, which would be really appreciated. Because we're getting some cat feedback is what it sounds like. I don't know what it actually is.

But I want to thank everyone for joining us. And so one of the things that we're going to have to do actually, I apologize. We're going to have to quickly mute everyone. And then we're going to have to ask our committee members to unmute. Because I think that this background sound will just be

too distracting for folks. So right now we're going to go ahead and mute everyone.

Operator: The conference has been muted.

Kate Buchanan: And what we're going to do is, we're going to ask our committee members to please unmute themselves. So I think, star 7. So to unmute your line, please select star 7 on your phone. Please make sure that your computer speakers are off so that we can avoid any feedback.

And as always, if you're not currently speaking, we highly encourage you to put yourself back on mute. So mute is star 6. To unmute is star 7.

And this actually brings us to a couple of quick reminders for our CenturyLink platform. So the link was in the agenda, as was in an email sent out right before this call. So we ask everyone to use the link to stream the slides.

We will say that Google is the preferred Web browser. But if you use another browser such as Internet Explorer, that is completely fine. But if you have Google Chrome, we do recommend that.

We also want to point out that participants have the option to listen to the Webinar either or phone or through their computer. CenturyLink is compatible with screen reader, for example JAWS. And here we have the phone number to dial in which is 1-800-768-2983. That is also on the left side panel of the CenturyLink platform.

So as we mentioned there are several different options of participating in this Web meeting. You can dial in, which provides you audio only. You can

stream the Web, which allows you to see the slides and listen but, does not allow you to talk and participate in discussions. Or how we recommend people participate is to stream the slides as well as, dial in.

So here we have a quick image of what you will see when you log into the CenturyLink Webinar. We have two functions in the bottom left-hand corner that may be of use, the Chat/Comment button, as well as the, Raise Hand feature.

And here you can see, if you click on the Chat/Comment, you are able to type out questions or comments to either NQF staff or, you can actually select a down button and click, send to everyone. The default is to send to NQF staff. NQF staff will read those questions and ask at the appropriate time, to make sure that those are communicated (unintelligible).

The other function is the Raise Hand. And when you select that, the text will turn from white to blue. That allows staff to know that you have a concern or a question and we can reach out to you. So that's something that - those are two things we wanted to point out.

As Debjani mentioned, we are joined here by our NQF staff. We have Debjani Mukherjee, Sam Stolpe, who are both Senior Directors on this project. Myself, Kate Buchanan, who is a Senior Project Manager, Yvonne Kalumo-Banda, who is the Project Manager, and Jordan Hirsch, our Project Analyst.

So here we're going to run through to see which committee members have been able to join us today. Once again committee members, to unmute yourself please click star 7.

So we have both Gretchen and Cheryl are here. I heard Glenda Armstrong. I believe you were able to join us. Is Pearl Barnett on the line?

Janis Tondora: Good afternoon, Janis Tondora is on the line.

Kate Buchanan: Oh, great, thank you Janis. Do we have Pearl Barnett on the line? And I believe I heard - is Sally Burton-Hoyle, are you on?

Sally Burton-Hoyle: Yes, I'm on.

Kate Buchanan: Great. Do we have Amber Carey-Navarrete?

Amber Carey-Navarrete: Yes, I'm here today,.

Kate Buchanan: Great. I heard Bruce Chernof is on the line.

Bruce Chernof: Yes.

Kate Buchanan: Do we have Bevin Croft? Okay. Is Amber Decker on the line?

Amber Decker: Present.

Kate Buchanan: Thank you Amber. Gail Fanjoy? Gail, I see that you are muted. To unmute your line, if you'd click star 7 but, we see that you are here. I believe Susan Fegen is on the line.

Susan Fegen: Yes, I'm here.

Kate Buchanan: Thank you. Do we have Sara Link?

Sara Link: Yes.

Kate Buchanan: Thank you. Joseph Macbeth? Okay. Denise Myler?

Denise Myler: Here.

Kate Buchanan: Thank you. And I believe I heard Melissa Nelson has also joined us.

Melissa Nelson: Correct.

Kate Buchanan: And Patricia Nobbie, are you on the line? Okay. Do we have Kate Norby? Kate, I see that you're on muted. If you click star 7 you can unmute yourself and we have you on.

Kate Norby: Thank you.

Kate Buchanan: Oh, great. Ann O'Hare? Okay. Do we have Leolinda Parlin? Okay. Has Richard Petty been able to join us? Mia Phifer.

Mia Phifer: I'm here.

Kate Buchanan: Thank you. Do we have Michael Smull?

Michael Smull: I'm here.

Kate Buchanan: Thank you. And I believe - do we have Dori Tempio?

Dori Tempio: Can you hear me?

Kate Buchanan: Yes we can. Yes, thank you Dori.

Dori Tempio: All righty.

Kate Buchanan: And I know we have Janis on. And do we have Maggie Winston?

Maggie Winston: Yes. Hello, I'm here.

Kate Buchanan: Wonderful. Thank you all. So before we get into the crux of the work, one of the things we want to do is review the project objectives. Just provide some clarification.

So as you can see on the slide we have five main objectives of this project which goes until August 2020. So in the course of eight Web meetings, the committee will refine the current definitions for Person-Centered Planning; develop a set of core competencies for people performing Person-Centered Planning facilitation; make recommendations to the Department of Health and Human Services on system characteristics that support Person-Centered Planning; develop a conceptual framework for Person-Centered Planning measurements; and to create a research agenda for future Person-Centered Planning research.

So during today's call we will be working on the second objective which is, to develop a set of core competencies for people performing Person-Centered Planning facilitation.

If you move on to the next slide, you can see where we are in the project. And one of the things that has been discussed by committee members is the trajectory and process of the project. And we appreciate those comments.

One of the things that we did want to say is that the content and process of this contract has been carefully thought out by both our partners at ACL and CMS, as well as, NQF staff. And with a lot of work we came to a consensus on how the project would flow. And so we are now contractually obligated to hit these certain objectives through these eight Web meetings, in a specific order.

We do want to say that there was a lot of work that went into how the work would be presented and developed. And we understand the concerns but, we really do think that the process laid out by both NQF, as well as, our federal partners, will really help achieve the goals of the project.

So we hear the concerns but, we did want to reiterate that this is something that has been thoughtfully planned. And that we are - we do have a contractual obligation to follow a specific direction.

And here you can see that we are on a second Web meeting of eight. And if we go on to the meeting objectives, as mentioned, today we will present the model of HCBS LTSS Institutional Care Transition. We will provide an overview of the environmental scan results: Person-Centered Planning core competencies. And we will gather committee input on Person-Centered Planning core competencies.

So we will have an opportunity for questions in just a minute, but I did want to go into a little bit of a recap from our previous meeting before we get into crux of the day.

So the staff incorporated committee feedback, as well as, input from our federal partners into the draft definition of Person-Centered Planning. This will be incorporated into an interim report along with the core competencies

of people engaged in Person-Centered Planning. That will be put out for public comment in November.

We do want the committee to know that they will absolutely have an opportunity to review the draft definition, as well as, the core competencies, prior to public comment. We envision this happening in September, and we will be getting more committee input on the draft definition and core competencies.

So this won't be a focus of our meeting today. But during our third Web meeting I think that we may address it again. And we absolutely will have more committee input prior to going out to public comment.

So even though it's not the focus of today, we don't want committee members to think that this work is finished. It is an iterative definition and we look forward to obtaining more feedback from our committee members.

Another thing that I wanted to address prior to getting into the crux of our meeting is the concern that we've heard both from committee members, as well as public commenters, in the express for a desire for the committee to receive additional input from self-advocates with lived experience in the areas of intellectual, developmental disabilities, autism, and dementia.

NQF took these concerns very seriously, and have engaged in some problem-solving and discussions with our federal partners. One of the things that we will do to address these concerns is that we are going to appoint four liaisons to our self-identified advocates living with lived experience in the three areas identified, who will participate in committee discussions and help advise the committee from their role.

So you may have received an email -- practically every committee member received an email -- asking for recommendations on people who they think would be good self-advocates to serve as liaisons to this committee. We're requesting input by this Wednesday, June 26. We will send a follow-up reminder after this Web meeting just to remind people that we are requesting this feedback from them. And so this just something that we did want to mention.

Additionally if there are other self-advocates with different lived experience that you think would be of value to the committee, please send those along. We do want to make sure that we get a lot of recommendations. Staff will be working to review and help identify the liaisons.

We will do orientations and help walk through the work done to date, as well as, set people up in order to participate and provide valuable input for our July 31 Web meeting.

So following this call, we will send a reminder email asking committee members to send along their recommendations for self-advocates whom they think will be served - would be goo liaisons to the committee.

And I know that we have just put a lot of information in front of everyone. And I don't want to take too much time with questions but, if you want to address any pressing concerns that may have come up in the first couple of minutes.

And if you have any questions you can also Chat them through the - so one of the questions we received from a committee member is, is there a different stream refining and defining Person-Centered Planning?

And so for the - one of our objectives was to refine the Person-Centered Planning definition. And so that is -- and let me pull that up as on our -- so when we say refine current definitions, what we did during the first Web meeting, as we looked at many different definitions currently in use to develop and to refine into a definition that this committee could agree upon, so that's what we mean when we say, refine.

It's taking from current definitions and combining and refining into a definition this committee can come to consensus on.

And I think those are all the questions that we have so far. So with that, I will turn it over to my colleague to get into the crux of the meeting.

Debjani Mukherjee: Thanks Kate. So this is Debjani. And what I will do is start off the presentation today about core competencies for Person-Centered Planning facilitation. And then I will be turning it over to Sam, my colleague, to continue the presentation.

So the first slide you see is a holistic diagram of how HCBS, LTSS, Institutional LTSS and the Inpatient/Acute Healthcare interact and how they fit into the larger healthcare arena picture. Next slide please.

In this slide what we present are sort of what we mean by competency, and what our goal is as far as core competencies go. So basically our goal is to develop a draft set of core competencies for people performing PCP facilitation. And a lot of this language is taken from our contract. And so we're presenting it to you to give you sort of a broader understanding of what the goal is for today, as well as, future meetings.

So the committee will refine the draft set of core competencies of people performing facilitation. And what we have done is started by summarizing some competencies. And finally, this deliverable will be finalized through ongoing iterative processes which include opportunities for providing input, as well as, the interim report as my colleague Kate had mentioned earlier.

So the goal is for the multi-stakeholder committee to consider the breadth and depth of PCP across various areas of healthcare and LTSS delivery while deliberating the core competencies. And for them to keep in mind the levels of complexity and domains of practice across the full spectrum of needs.

So that is sort of the goal here. And as staff, our job is to sort of facilitate and help our co-chairs facilitate a conversation to determine the best set of core competencies.

So what staff has done in the background is, review competencies identified through NQF searches and then an environmental scan. And the environmental scan contained 28 PCP facilitation methodologies. So we did our own search as well as, look at the scan of all the different facilitation methodologies and start compiling a list of the competencies that either cross all methodologies or, were (unintelligible) to each.

The other goal is to develop a generalized model for core competencies for facilitation PCP at HCBS, including shared decision-making when transitioning from different settings. And you will see a diagram coming up that sort of is a pictorial representation of this slide.

So this slide shows you sort of the interaction and touch points of all the different settings we're talking about. So we have HCBS, we have facilitation care, we have institutional LTSS. And for each of these there can be multiple

points of interaction in-between these three bucket areas. And for each of these transitions there's Person-Centered Planning as well as, shared decision-making.

And we also give you some examples such as for acute inpatient care, we have short stay nursing; hospital stay; emergency room. For Institutional LTSS we have hospital; nursing home; mental health facilities; institutions for (unintelligible), etcetera. And looking at the triangulation and (unintelligible) for each of these, and how we can facilitate Person-Centered Planning, as well as, shared decision-making (unintelligible).

Man: Can we have the person who has the dogs behind them put themselves on mute, please?

Kate Buchanan: And star 6 is mute. Star 6. Thank you. Wonderful. Thank you very much.

Debjani Mukherjee: So this slide has question marks around the interaction touchpoints. And basically that's where the core competencies fall and will be discussed. And those are the areas where the core competencies become important and help facilitate the process of Person-Centered Planning, as well as, shared decision-making.

In the next slide what we do is provide a representative sample of the setting that fall under each of the three big buckets that you just saw in the diagram.

So we have HCBS, we have Institutional, and then we have Acute Inpatient Care. So for HCBS we have some examples of an individual personal home, integrated community based day settings, specialized family care homes, group homes, assisted living, places of employment, etcetera. And again, this is a representative sample and not an exhaustive list.

For institutional LTSS and long-term facility based settings connected to inpatient treatment, we have nursing homes, hospitals, institutions for mental disease, etcetera.

For Acute Inpatient Care we have emergency rooms, hospitals, hospital settings. Short Stay we have facilities, post-acute care settings, etcetera.

For the next slide we have a representative sample of services that each of these settings provide. And for HCBS we have examples such as personal care; supported employment; residential treatment services; pre-vocational services; transportation; home repairs; modifications; homemaker and chore services, etcetera.

For Institutional we have diagnostics…

Woman: I'm sorry, hang on. Hang on one second. Can we have them go to the next slide please? We should be on Slide 25 now. There we go. Thank you.

Debjani Mukherjee: So for Institutional we have diagnostic services, preventive services, therapeutic services, etcetera.

For Acute Inpatient Care we have emergency medical treatment; hospitalization; hospice, end of life care, etcetera.

And with that I'm going to turn it over to my colleague Sam, for the rest of the presentation.

Sam Stolpe: Very good. All right, hi everybody. Sam Stolpe here. So just a brief reminder about where we are at and why we're going through each one of these.

So the next couple of slides I'm going to walk through the actual findings that we had from the environmental scan, including those 28 methodologies for Person-Centered Planning facilitation.

Now within those 28 -- excuse me -- facilitation methodologies, we found a number of core competencies that we thought were particularly relevant, and that we wanted to invite the committee to weigh in on.

But the most salient feature that we thought about this was that, it wasn't just the HCBS setting that these Person-Centered Planning facilitation methodologies were embedded in. And our team and our federal partners thought it was really important to emphasize that point.

That necessarily, persons inside of the community need to be considered inside of the complexity of the environment that they're in. That they can easily transition from both acute and long-term care settings and back to the community.

And that the Person-Centered Plan should be traveling with them. And there may be some changes in the sorts of skillsets that we expect persons who are conducting and facilitating that Person-Centered Planning process, to have. And that's what we're hoping to ask you about.

So when I start reading through these competencies, I want you to think about a couple of things. First, all those care settings that Debjani just mentioned,

and anything else that may come to mind that may add complexity. But specifically to get us to this core competency list.

So think about it in those terms as, when we hand it over to the co-chairs, they're going to invite you to weigh in on exactly those points. So both the care settings and the complexities (unintelligible), but specifically, how the leads to different levels of need for competency in persons who will be facilitating the care.

And I hope I'm not over-explaining this. But just want to make sure that this is really well understood by everybody on the committee. Okay, so…

Kate Buchanan: And Sam, we have been getting some inquiries of whether or not there will be time for people to react to these slides, as well as the information that has been brought forth. And so wasn't sure, just so committee members knew, when would be a good time to have discussion about all the information provided.

Sam Stolpe: Great. Yes, sorry if that wasn't clear. So I'm going to go through just these next few slides and then we'll you know we'll just explain five or six slides here that's going to outline what the results were of the scan.

And I'm going to go through it slowly so you can think about it. But we're going to go back under a facilitated discussion by our co-chairs, to help us to get through exactly what you had in mind there. So thank you for that question. I think it's a really important clarification point. And sorry if we weren't clear on that.

Okay, so let's go ahead and dive into these competencies that we found through the environmental scan.

The first section that we grouped was under foundational skills. And I'll stop shy of reading the whole slide. But just wanted to highlight a couple of bullet points. For example, the first one, self-awareness, was something that was heavily emphasized and we found repeatedly through these methodologies.

And that included a lot of things such as cultural assumptions, personality dynamics prejudices, and how those actually come into play for persons in the community. And what it means for developing a plan.

We also saw that understanding group power dynamics for both family and systems inside of their cultural context for example. That ends up being a very important foundational skill for people who are facilitating Person-Centered Planning.

Some others on here - cultural humility and competency, openness to learning, critical and creative thinking, qualitative (unintelligible) methods was one that got listed as well. Let's go ahead and go to the next slide.

We also found another grouping of skills that we characterized as relational and communication skills. And those included negotiation; dispute resolution; engagement skills; active and reflective listening; team building; and customer service. Let's go to the next slide.

Now there are some competencies that still are under more of a philosophical domain as well. And we expect that those who are conducting Person-Centered Planning facilitation have some - just an understanding of the philosophical underpinnings of Person-Centered Planning and the movement that it's predicated upon.

And some of those that we saw inside of our search were around effective freedom, recovery, and empowerment.

So our next slide we're showing some of the knowledge - resource knowledge type competencies that were expected. And I'll highlight a few of those. There's the expectation that persons conducting this should be understand long-term support service and support the larger healthcare system broadly.

They should understand safety net providers; populations and subgroups; local advocacy groups and individuals; gaps in services and support, etcetera.

Okay, and I believe this is our last slide before we hand it over to our co-chairs for discussion. But I just wanted to highlight a couple of other things that we found under the policy and regulatory context.

So things like human rights, Olmstead, Americans with Disabilities Act, independent living philosophy, and the social model of disability, all emerged from our environmental scan.

Okay, well let's go ahead and go to the next slide. And this is where we head into our discussion. So we're going to hand it over to our co-chairs to lead us into it. But we just had a couple of questions here to tee it up so, Cheryl and Gretchen, you're up.

Cheryl Phillips: Wonderful. This is Cheryl. And Gretchen is on as well. So I think that these three questions are a good place to start and I'll look to Gretchen as well but, I think starting with number one. And I think this also ties into some of the conversations that we have heard from you between calls.

So first all, have all the necessary Person-Centered Planning competencies been captured? And I'll acknowledge that competencies are a journey, not a destination. So we fully appreciate that it's not a checklist. I read something, I'm competent, I'm done.

But we're trying to look at these as broadly as possible so that it is the understanding that competencies are an engaged, ongoing process. Gretchen, anything that you'd like to add?

Gretchen Napier: Yes, I think I would just ask that if anybody wanted to talk about a specific slide, to sort of direct us back to that slide so that everyone can see what you're looking at, if you're talking about something specific. Otherwise obviously, just general comments are fine as well.

Amber Carey-Navarrete: So this is Amber. You're facilitating by seeing whose hand is raised?

Kate Buchanan: No. We're going to ask committee members just to vocally participate.

Cheryl Phillips: So if you are on mute, obviously unmute. Please identify yourself. And then we can manage the discussion. Gretchen and I cannot see the hands raised. So we we'll be doing this by audio.

Sally Burton-Hoyle: This is Sally Burton-Hoyle. And I guess I'm kind of concerned about what isn't here as a competency. And that is, knowledge of the individual and a relationship with the individual.

So these are boilerplate sorts of things that any of us who've been facilitating. But what self-advocates want is for somebody that values and understands them. And perhaps even have a relationship with them. Where's that?

Cheryl Phillips: That's an excellent recommendation. So person specific or individual specific knowledge. Who is this person that I'm facilitating with and what matters to them, right?

Sally Burton-Hoyle: Yes.

Gretchen Napier: What other competencies - go ahead. I was just going to ask for others. Go ahead.

Amber Decker: This is Amber Decker. I had just sent most of my questions through the Chat and in advance. If you can please, my feedback is in regards to Slide 23, in which there is listed various areas of like - I guess these are places where HCBS and Person-Centered Planning are, you know, supposed to be facilitated or hopefully are facilitated. Is that correct?

Gretchen Napier: Yes.

Amber Decker: Okay. So I just - my feedback was to add other areas like social services centers. Sometimes they're called local department of social services. Outpatient clinics, single points of access, parents, peers, and special education or Department of Education which also could use a good lesson in Person-Centered Planning, because they were missing. So that was one thing.

Then the other thing that I would like to address is Slide 25. I was hoping that under HCBS you can add, self-direction, because it is a service, or self-directed care. I'm not sure if it's on there and I might have missed it.

And I also wanted to propose a question in regards to Person-Centered Service planning. So do we - can we agree or think about Person-Centered Planning

as a service in itself. And you know, maybe include in the environmental scan, a review of states that might be already providing Person-Centered Planning as a service. So that was it for my verbal comments.

Gretchen Napier: Thank you Amber.

Melissa Nelson: This is Melissa. I just want to echo the earlier comments about the importance of a commitment to and understanding of, self-direction and self-determination in the competencies. Along with the dignity of risk and the importance of facilitating informed decision-making.

Gretchen Napier: Thank you Melissa.

Cheryl Phillips: This is Cheryl. I think both of those additional concepts are very important. The idea of dignity of risk and informed decision-making. Yes, thank you.

Amber Decker: This is Amber Decker. I just wanted to add one more thing. I think that time and case load should be added to the core competency. Because if you have a case load of 80 or 100 individuals that you're serving, it is not possible to facilitate Person-Centered Planning. So I think a basic, you know, consideration of a care manager or a coordinator's time and case load should also be added to your competency list.

Cheryl Phillips: And while that may -- this is Cheryl again -- while that may not be a competency in the way we think of a skillset competency, it is an absolutely critical function and operational aspect in order to achieve the goal.

So yes, if it's not included under competencies, it needs to be included somewhere else under an operational structure.

Amber Decker: Well then maybe time management. Sorry, this is Amber Decker again. Maybe time management or consideration of time management. Something along those lines.

Cheryl Phillips: But a point well taken, thank you. A case load of 300, you're not doing Person-Centered Care Planning.

Dori Tempio: This is Dori Tempio. Could I add something?

Cheryl Phillips: Please. Are you one of the…

Gretchen Napier: Go ahead.

Dori Tempio: Yes, I'm one of the committee members. Is that all right?

Cheryl Phillips: Yes, please.

Gretchen Napier: Yes, please.

Dori Tempio: I wasn't sure who was talking and I didn't want to cut anyone off. I also would like to see, I would back up with what all the other people just said about self-determination, self-sufficiency. And I'd like to see consumer control added to there.

I think that's important. This isn't about me or someone planning someone else's life. This is about the consumer having control of the choices that their life takes. That they want for themselves.

Gretchen Napier: Here, here.

Cheryl Phillips: Absolutely. Thank you.

Dori Tempio: Thank you.

Bruce Chernof: This is Bruce Chernof. I just wanted to weigh in and say, I'm totally supported of the comments that have been made so far. But I think we need to recognize - I just to acknowledge that when we're talking about person-centered support, various people need various things.

And people want varying levels of independence and help. Whether they want their circle of support or caregivers may be another word, how engaged or not engaged in that decision-making.

And so I just want to be sure that our comments don assume that everybody wants to make every decision on their own. Because that's not always the case.

Gretchen Napier: Respectfully sir, I think if we start out that way, we'll start out with a bias towards making decisions for people.

Bruce Chernof: I think we need to ask people how we can most be helpful, respectfully.

Patricia Nobbie: This is Pat Nobbie. I'm putting myself in the Chat box because I'm at the airport and it's very noisy here. So is anyone reading the Chat box?

Kate Buchanan: Yes Pat we are and we apologize. We have been receiving many comments and we did see yours though. And we will get to it and read it aloud as soon as we can. My apologies.

Patricia Nobbie: Okay, I just wanted to make sure. Thank you.

Kate Buchanan: Yes.

Cheryl Phillips: Well if we have a pause right now, maybe it's good to go back to some of the Chat questions that you all have put in, since Gretchen and I can't see those. Is this a good time staff?

Kate Buchanan: Yes. So we have Pat Nobbie's comment. And said that under Philosophy, dignity of risk. And under Foundational Skills, recommend reported decision-making. So those are two of the suggestions from Pat.

Many of the other questions we have gotten or comments have been from the public. And we of course appreciate the comments but, one of the things we do encourage people to do is, we will have an opportunity for public comments.

So as we may not be able to address many of them now, we will have an opportunity for public comment at 4:00 p.m. So just recommend or would highly encourage people to give those comments verbally during the 4:00 p.m. public comment. But I don't see any other questions from the committee in here.

Gretchen Napier: Okay great. Well then we'll just continue to do it verbally. Who else on the committee would like to make a verbal comment? Or have questions?

Amber Decker: This is Amber Decker. I'm sorry, I did send questions in advance and I don't mind reiterating a few of them if that's something that I can do. Again, the rules around how to participate here are a little murky for me so, forgive me.

So I had some questions around Slide 26, 27, and 28 in terms of how NQF has actually, you know, collected the Person-Centered Planning competencies such as the foundational skills and the relational communication skills. I just wasn't sure.

And also, Slide 28 has the word, recovery. And I felt that that is somewhat of a loaded term, especially for individuals that there is no recovery in sight for them. They're permanently disabled. So I'm not sure how recovery is being utilized in this context but, I think it's important to make a distinction.

Debjani Mukherjee: Thanks Amber, this is Debjani. I'm going to take a crack at both of your questions. So the first one is, we did look at state PCP Programs. So we looked at a sample of programs. We looked at the environmental scan, as well as, come federal documents to come up with the core set.

We also worked with our federal partners to make sure it is sort of a good first step at having this discussion today. So as we said, it's representative; not all exhaustive. Which is why we are presenting to the entire committee for input.

And for your second question about the word, recovery, so we are looking at the entire spectrum of care. So in an effort to be inclusive, we have recovery for those who are on the path to recovery or, you know, at some point of recovery.

So we realize that there are some individuals who are permanently disabled and will not recover. But we also have - and we also have from our ACL colleagues, who's also about, when we talk about recovery, referring to mental health and substance use disorders. So did want to provide that additional clarification. Thank you very much (Sean).

And we do have a couple of questions in the - or comments in the Chat box, so wanted to read those. So we have another one from Pat saying, regarding the supported decision-making, this might address Bruce's concern. Supported decision-making enables people to be proactive on the decisions they want to make and the ones they would want assistance with. That was one comment.

We also received a comment from Dori saying - questioning us to not assume that people with disabilities, no matter the significance, can't make decisions. And that it can assume that people automatically want and need help. So just cautioning us about that. So we appreciate those comments.

I'm looking though, and those are the only two committee comments we have in the box.

Sally Burton-Hoyle: Hi, this is Sally Burton-Hoyle. And then in Michigan we, in our definition, we've got a place where we look at people's skills and strengths as well as, needs. And we kind of start off with that.

And I don't see anything in the competencies that address the ability to find somebody's skills and strengths.

Gretchen Napier: Thank you for that Sally. That's a very helpful recommendation. We appreciate that.

Okay, there are quite a few people we have not heard from at all. So I'd really like to make sure that we get comments from those who have not yet shared their perspective. If you haven't shared yet would you mind jumping in here and telling us what you think is missing or, what other categories or skills need to be added.

Glenda Armstrong: This is Glenda Armstrong. And I just wholeheartedly agree with the comments that have come through so far. One of my biggest concerns was that the individual was lacking and that that really should be the focus.

And I think maybe to sort of mitigate some of Bruce's concerns, that includes - I mean that means that it's based on what the person is wanting. Whether that's a lot of facilitation or a little. A lot of support or a little. As long as it is very well informed, I mean that is our job to make sure that it is.

And otherwise I just think the individual, just no matter what the circumstances of the individual, that should be the focus.

Gretchen Napier: Thank you Glenda.

Glenda Armstrong: Mm-hm.

Gretchen Napier: Who else would like to share from the committee?

Denise Myler: This is Denise Myler.

Cheryl Phillips: Hi Denise.

Gretchen Napier: Go ahead (Judy).

Denise Myler: (Judy), why don't you go ahead and go first. This is Denise Myler.

Kate Buchanan: I'm not sure we have a (Judy).

Denise Myler: Okay. Then I will - back on Slide 28, as I'm looking at this, what are you guys meaning by, effective freedom?

Debjani Mukherjee: So, this is Debjani again. So that list, we worked on with our federal partners. So (Sean) from ACL, would you like to say a few works about, effective freedom? But we wanted to make sure that freedom was captured. And we looked at some of the documents that were provided. And the term coined and used is, effective freedom versus just blanket, freedom.

Kate Buchanan: And (Sean), you can either type into the Chat box or if you hit star 7, you can unmute yourself. And while we wait for that.

(Sean): Can you hear me?

Kate Buchanan: Yes.

(Sean): Good. Okay, so effective freedom is the idea basically, that we have these ideas that we're free to do what we can. But we actually, if we don't have any money, don't have any transportation, we don't have the means to actually implement or effectuate the freedoms that we say we have, then we don't have a - we don't really have freedom.

So effective freedom refers to that sort of reality. Which is the reality for many, many people with disabilities and older adults. And so that's kind of the broad meaning of the term.

It started - I think the first I heard of it was through a Development Economist, Amartya Sen, who wrote a book for the lay people like me, Development as Freedom. And he goes into great detail of what that means.

So I just thought - I think that we - I've seen it used here and there in our work. I thought it would be useful to add as a concept. And feel free to debate.

Debjani Mukherjee: Gretchen and Cheryl, we did receive a comment from Gail, one of our Committee members, supporting the comments brought forth today, especially knowledge of the person who is the focus. But that is the other comment we received in the box.

Cheryl Phillips: Thank you. And I am hearing that as a recurrent and important theme. In fact, it's foundational to all of the other competencies.

Bruce Chernof: This is Bruce Cheryl. And I would strongly agree with that.

Glenda Armstrong: Me too. This is Glenda.

((Crosstalk))

Janis Tondora: I'm sorry, this is Janis Tondora. Can I add a few things?

Cheryl Phillips: Please.

Janis Tondora: I certainly want to echo other folks on the line in support of the comments. A few things that stand out to me, I'm not sure where it would fit. Maybe it fits under philosophy in the Empowerment bullet. Or maybe it fits under relational in the Engagement bullet.

But it seemed to me that in the implementation of person-centered care planning, there's often a tremendous amount of effort that goes into talking

about competencies and skillsets and building confidence among professional facilitators.

And I think (unintelligible) a true partnership based model. You have to build capacity on both sides of the partnership equation. So I certainly see it as a kind of a core competency to be able to talk to someone about what their planning preferences are. What their needs are, and how do they have the voice in their planning and their services that they want to have.

And actually being able to either yourself, or to connect them to for example, a peer support organization that actually do some kind of core skill building and capacity building around being an effective leader of your person-centered care plan.

So I think that direct education of the person with the disability is a competency. I also want to echo that I think we do have to be careful about making assumptions around the level of control and decision-making that people want.

And I could absolutely say that the vast majority of times people want control over decisions that, you know, that impact their life, that impact their experience of care.

But I think we also need to recognize that the whole idea of self-determination and individualized decision-making is a very (unintelligible) concept. And not embraced always cross culturally, or certainly even within cultures.

So I think competencies need to recognize that there's variability there and that's kind of critical.

And then the last thing that I will - well actually two more quick things. There's a reference to the social model of disability, which I think is important. However, I think even beyond that, when we start talking about competencies, it's one thing to conceptualize from the social model of disability. But to be able to act on it effectively as a Person-Centered Planning facilitator, I think increasingly there is a whole body of literature and interventions around the social determinants of health.

And I think that's really - those are growing, innovative, evidence-based practices that people really should be knowledgeable of and skilled in.

And so those are my initial remarks. And I'm going to mute my phone line again because as I said, I'm traveling. I apologize for background noise.

Gretchen Napier: Thank you. Those are excellent points. Really appreciate you sharing those with us.

Glenda Armstrong: This is Glenda Armstrong. And I have some further questions about, effective freedom, because I too was a little confused by that one. And just the terminology sort of denotes that we mitigate the freedom by what resources are available.

And I'm not sure I can agree with that. Forgive me if I've misunderstood. Could we talk about that a little bit more?

Gretchen Napier: NQF staff?

Debjani Mukherjee: Yes, this id Debjani. And so from - building on what (Sean) said, it's sort of to look at sort of the practical implications of sort of facilitating freedom.

So looking at resources and handle of resources like caregiver, money, community. And that very well gets into the whole discussion of SDOH - social determinants of health, as well as, sort of moving from the conceptual model - a social model of disability to actually a practical application.

So I think that freedom aspect gets to sort of, everybody should have the freedom to choose their sort of person-centered plan. But to act - to sort of go from sort of the conceptual exercise of choosing a plan to, actual practical application of the plan that effective freedom looks at resources available; needed, to actualize the plan. And (Sean), please correct me if I may have taken the definition further.

(Sean): No, that's great. I just - this is really a practical question. So you want to say, just to use an example of somebody who's in a group home with four or five other people. They want to move out of the group home. They don't like it there, right.

So now what does that take? That takes, you know maybe for this person, a number of pretty significant resource allocation questions. For instance money, to move to an apartment. They don't have the ability to do that. We all, technically in a philosophical sense, have the freedom to live wherever we want.

But for many, many people, the resources that are necessary to live where we want, do not exist in a way that is comparable to the average person, for instance.

Same thing with nursing homes. I mean maybe we could ask a whole bunch of questions. The question is, how do you effectuate the stuff that you want to do? And how is that significantly diminished among many of the people that

are served under these programs? And I think that's a reality that we need - that has to be - you can't do this work without being aware of that kind of thing.

You can call it something else you know, like effective freedom. But I think the reality of not being able to actually live the life you want to live in a community the way you want to live it, is the issue.

Kate Buchanan: And we have a couple of comments in the box that I wanted to bring up, from committee members.

So Kate Norby agrees with the addition of strength based discovery, as well as, self-determination and direction.

Amber Decker: This is Amber Decker. I just wanted to add one more thing like cross benefit analysis or an expected value. I mean, does the individual that's willing to engage with this action, you know, will they have - will there be something they get in return?

I do think that the expected value of Person-Centered Planning is never quite clear for individuals that are engaging in it. So I don't know if that's something that - to be listed as part of one of the core competencies. That whoever is facilitating it should know what the expected value. Or should be able to explain what the expected value is, of participating.

Kate Buchanan: Thank you Amber. So just wanted to finish off reading the committee member feedback that we had gotten in the box. Wanted to make sure those voices were heard.

So Kate Norby agrees with the addition of strength-based discovery, as well as, self-determination and direction and supported decision-making.

Received feedback from Amber Carey-Navarrete. All of the feedback I have shared this morning through emails and expressed, so just wanted to reiterate some of the discussion. I agree that more control by the person needs to be representative. Also, dignity of risk and supported decision-making are missing concepts. Flexible and adaptive listening for a variety of communication styles and barriers is an important skillset needed. Also, I prefer the term, empathetic listening, instead of, active, since it expresses trying to listen to the person's life perspective.

We also received a comment from Susan Fegen on the committee. As you discussed earlier, the need for a manageable case load to ensure good Person-Centered Planning. We also need to establish that there is a need for reasonable timeframes to complete the plan. Many states have given the facilitators a very limited time to develop time, as short as five days and as long as 30 days.

And then we also - so we have additional comments from Susan, Pat Nobbie, and Dori. And wasn't sure, let's see Sally, there was a question you had was, isn't Person-Centered Planning the expectation for all in the system? And so I wondered if you would maybe expand upon that a little.

Sally Burton-Hoyle: Well, it seems like some of the -- and this is Sally -- some of the recent comments are kind of like, if people want to do this, then if people want that.

And I think that it's - in our mental health code mandate in our state, and there are all together too many professionals that are kind of adopting that, well I don't know if they want to do this, and so they don't do it.

But as I understand it, and so that's why I was asking, isn't it the expectation that Person-Centered Planning, which is then a variety of different ways, depending on what that person's life is and what they want it to be. But regardless, shouldn't it - so the (unintelligible)?

Debjani Mukherjee: Yes, it's for everybody. So even though some of the discussion has focused on maybe certain individuals with certain characteristics or sub-populations, this is an exhaustive project. So we are not looking at a particular person with certain characteristics. They're looking at individuals who may have one of many different characteristics and permutations of different conditions and characteristics, correct.

Sally Burton-Hoyle: And this is Sally. And I'm borrowing from (unintelligible). We really have as one of our competencies in trainings in Michigan, that you have to understand the individual's behavior as communication. And that regardless of if they are in a hospital bed and non-verbal, or able to direct (unintelligible), that we still recognize their behavior as communication.

And kind of back to - I'm kind of sorry I'm going to be a stickler on this, but I kind of don't like the term, population. Because if we are thinking about Person-Centered Planning and not being a medical model, I think in this committee we really should not use the term, population. Just my thoughts. Thank you.

Kate Buchanan: Thank you. And Cheryl and Gretchen we have one more comment from Dori that I want to read, and then we can go back to the verbal discussion.

And Dori writes that the social model says the world around us is inaccessible. And by limiting people's options and assuming people's capabilities you are

not giving access. She is very concerned that we're worried about caseloads rather than promoting choice, self-advocacy, self-determination. Choice means -- my apologies -- choice means just that, equal option for community living for all.

So just wanted to read that comment aloud. And that's all we have from the committee members right now.

Gretchen Napier: Okay, thank you.

Michael Smull: This is Michael Smull. A couple of things. One, I sent an email earlier, and that contained much of what I wanted to make sure we included. But I want to emphasize that the person who is facilitating the Person-Centered Plan, if it is not the person, one of the core competencies is to be able to assist that person in facilitating their own plan.

In the email I said that there's process experts and content experts. And you want the process expert to be prepared to support the content expert in becoming a process expert.

The second thing was, as a core competency, to be able to communicate to learning effectively. In long-term supports and services, it's the person's plan. But you want that plan to be used by people who may have never met the person.

So what's in the plan needs to be effectively communicating to people who are going to be responsible for implementation. Which also takes you back to what - the issue of effective freedom. Because a brilliant plan that's not implemented is a disservice to the person. And in many cases it's traumatic.

Amber Decker: This is Amber Decker. I absolutely agree with that. And the one thing that I have found very frustrating in Person-Centered Plans that I have seen is that lack of implementation and what to do once that is the case. So I think that that's - there does need to be, you know a partnership.

Gretchen Napier: Thank you all both for that. Yes, and the process and content expert Michael, is a great way to think the different skillsets that are needed. So thank you for bringing that to the table as well.

Who else has other comments or things that they think need to be added skills or categories?

Melissa Nelson: This is Melissa Nelson again. Just following on watching our terminology, so if we're trying to avoid referring to people as populations, one thing that we're really working on where I'm working is to eliminate the word, case. Because people are people and they are living lives. They're not cases.

So I haven't come up with a good, other word for caseload yet, but we're trying to eliminate that word all together from our vocabulary.

Gretchen Napier: Good point.

Denise Myler: This is Denise Myler.

Gretchen Napier: Hi Denise. Go ahead.

Denise Myler: Following up on what Mike said, should we not somewhere, as a part of our competencies have the implementation of the plan be one of the competencies? I would like to see that as a competency. Otherwise…

Amber Decker: Ensuring that it's implemented.

Denise Myler: Yes. Because if we don't ensure its implemented we've wasted…

Cheryl Phillips: Yes, exactly.

Denise Myler: …my time has been wasted in developing my plan and working with others, if it's not going to get implemented.

Gretchen Napier: Thank you. That's a great suggestion. What else?

Sara Link: This is Sara Link, and I just had some thoughts. And I just, kind of, wanted to lay this out to the group. I'm thinking, you know, for (Trina), we do Person-Centered Options Counseling and I'm just wondering if anybody - thoughts around laying out a menu of options available to the individual or what - (if that), we feel like should be something that's presented in this.

Amber Decker: I didn't hear what you said or was it - Person-Centered - I'm sorry, can you just repeat the term?

Sara Link: Yes. We - it's Person-Centered Options Counseling. And so as we do Person-Centered Planning and we think about different types of service support goals, resources available to that individual, where do we believe, in this process, of empowering the individual so that they understand different options available to them?

Amber Decker: Well - this is Amber. I - this is Amber Decker. I just wanted to say, I think that Person-Centered Planning as a service is something that I had mentioned because I wasn't sure if it was captured in our competency set. Just, you

know, because it often is a service and but it feels like a service and yet it's not called a service.

And so I think it's confusing, you know, to know whether it is a service or if it's a process. I mean, it is a process, but it - a lot of people think of it as a service. And so, I don't know if we need to ask or include that in the scan to see what works, you know, and what doesn't.

Gretchen Napier: That's a great point. All right, anybody else have categories or skills that they think need to be added?

Glenda Armstrong: This is Glenda Armstrong and I was looking back at the foundational skills and there - that the first bullet point is about self-awareness and cultural assumptions. I wondered though, I think I was wanting to feel more emphasis on what, you know, a great Carl Rogers once said and that was, "Unconditional positive regard for people." Which it means that your interactions are - and your communications and your work is without judgment.

And even though folks are making decisions that you don't want them to make but your job is to support what they want and you don't, and not to have preconceived notions or judgments about their decisions or their situation.

We often see this with people who have addiction disorders, some health disorders is there - a lot of preconceived notions about those behaviors and unconditional positive regard with no judgment is absolutely critical to being successful when supporting them.

(Laura Sutt): This is (Laura Sutt), I couldn't agree more. Thank you.

Man 1: (Perfect).

Gretchen Napier: Thank you.

Cheryl Phillips: This is Cheryl. So along with the additions, it seems like, to me, maybe there are also some areas where we can combine into a more global comprehensive term. So I think what you just offered was a good example, that if you truly do have that scope of total person-focused setting aside judgments that many of those elements in that first category are all bundled up under one.

So if there's other areas where people think that we can combine some, that would be helpful feedback as well. So I'll pause here.

Cheryl Phillips: All right, (Nia).

(Nia): Oh…

Cheryl Phillips: Yes.

(Nia): …sorry. Well, I was going to say, we did get a comment from Pat Nobbie saying that unconditional positive regard also contributes to what I mentioned about not presuming that because the person is lacking personal resources they are not capable of making decisions on their life.

And we did receive another comment from (Pearl Barnett), a committee member, saying, "One thing that has not been mentioned is effective communication skills, both written and verbal."

Cheryl Phillips: Yes, I mean, I think it's very important to call that out. You're right. I think a lot of good words under those categories but calling out effective communication skills is (unintelligible).

And the idea that the - so I will add now - this is Cheryl - adding in my own thoughts that it is so often easy for us - so I'm a physician, and very often we physicians assume that our judgment is the correct one and that people have decision-making capacity as long as they agree with us and they don't have it if they don't agree with us.

And so in Person-Centered Planning, I have to put aside that assumption that even if someone has some cognitive challenges, whether developmental or from (dementing) illnesses, that their shift in cognition don't imply their lack of ability to make Person-Centered choice.

And I know those are a lot of words. And I think that they are varied in what people have been addressing but it's putting aside those assumptions that because they agree with me, those are good decisions; if they don't agree with me, they're not good decisions.

Amber Decker: This is Amber. I just wanted to go back to Slide Number 26 one more time and make sure that honesty and communication, which are real basic tenets, are included because while all these other wonderful things there, I think that, you know, honesty and communication are two huge things that need to be emphasized on.

Gretchen Napier: All right. (We) also commented about either - oh, go ahead.

Sam Stolpe: Well I was - this is Sam Stolpe. I was (potentially) going to - taking a look at the time that we have remaining and what else we're looking to accomplish

with this and was going to invite one or two more comments before we move along to the next portion of that conversation.

Denise Myler: This is Denise Myler. As I've been sitting here thinking about it, somebody mentioned consolidating some of these. Are we wanting to consolidate or do we maybe need to add a couple more competencies that would better fit some of our suggestions?

And we might do either. I was looking at one of the bulletins - or the bullet points. So we are talking about, we've been doing a lot of added comments - additive ideas. Was there a way to consolidate? It was not a mandate or a request but I think your thought, and if you have language to offer, then maybe there are ways to better state some of these that might combine a number of the issues that were on the bullets as well as what the group has brought forward so it's not an either/or.

Amber Decker: I'm sorry. This is Amber Decker. I think we need to add, personally, I mean, we're talking about foundational skills for individuals…

Denise Myler: Sure.

Amber Decker: …that are providing a Person-Centered Planning, correct?

Denise Myler: Right. And yes, and so nobody was saying that we shouldn't add but then the other question was up to the committee, "Are there areas where you wanted to combine, and if they're not, that's fine." That was just an exploratory question.

Amber Decker: Well I do think that bullet - they're not numbered so it's a little hard. But I think cultural…

Denise Myler: Yes.

Amber Decker: …humility competency is a bit somewhat redundant because we have the first bullet that says, "Self-awareness, cultural assumptions." I mean, I don't know if there's a way to make that clearer or…

Denise Myler: Yes.

Amber Decker: …less redundant but I think it's relevant to…

Janis Tondora: Hi, so this is Janis Tondora. I'd like to add something or maybe it's more of a question for the group to consider. I don't (unintelligible) (think this fit) (unintelligible) -- regulatory domain or the skills domain. But I think some kind of competencies that speaks to a (facility leaders) ability to accurately reflect in their written document…

Amber Decker: …yes.

Janis Tondora: …what a Person-Centered Plan actually looks like and the fact that it is very possible to write a plan that honors the person and their choices of life in terms of wanting to live in the community and to do that without compromising the necessary pressures that people feel from a regulatory and a treatment documentation perspective.

This is something that's a very practical thing that I think we need to consider because at least in my experience, especially within the behavioral health arena, one of the most significant obstacles at times to implementing this is the perception that we can't write plans and co-create them with people that honor a person and (also) satisfy a chart.

If you will, I certainly believe that we can. I've dedicated my career to that but there are very real concerns in the field around that. And I think that some knowledge, some skills, some understanding around what that looks like is an important competency that we make sure we have a document that is actually co-created and that can help shape a person's tackling, moving forward in a meaningful way.

Sam Stolpe: Okay. This is Sam Stolpe. Thank you so much for this dialogue that we've had thus far around the core competencies. I'm going to walk us through two more slides before we re-engage in a discussion that adds another layer of complexity. So if we could go to Slide 33?

All right. So this is just revisiting the - a Person-Centered Planning by care domain and you'll notice these little question marks around the transition points. And this is the level of complexity that I was talking about that we'd be able - that I wanted us to discuss.

So you notice that we had a pretty big list of care settings; we had a pretty big list of core competencies; and we've invited you to have a rich discussion around this. And we're going to look for ways, as the NQF team, and working with the committee, to try to consolidate things a little bit later but for now it's fine for us, it's just try to come up with as much as we can.

So this next layer that we're going to add won't necessarily add a lot of complexity but what we're trying to get to is a generalized model. It's simply not possible for us to list out every single possible competency that someone might have specific to an individual case.

And I'll show you the individual case that just highlights how complex this truly can be. But we also thought it would be very useful for us to think about things in terms of nuance that might help us get to those generalities so that we can get to these general levels of complexity that we think are especially important as we're talking about the core competencies in levels. So not just at the lowest common denominator but what are the additional levels of complexity that we should be considering and what are some of the core competencies specific to that.

So we have this very simplistic model that we've depicted here on Slide 33 that describes how this Person-Centered Plan and shared decision-making should occur whenever an individual transitions between certain care settings. But now we're going to invite you to talk to us about what that actually looks like so let's go to the next slide.

Now this is just an example. It's not intended to be anything other than to highlight the sort of complexity that we'd like the committee to think about as we're coming up with these core competencies and the, sort of, specificity that we'd invite you to consider.

Now this particular example, (of course), is representative of a very important type of adults in the community but it's by no means meant, sort of, be exclusive. So forgive us that we didn't list out everything that we could think of but we just wanted this more as a highlight.

Okay. So I'll read parts of this slide and then I'll hand it over to our co-chairs to lead the discussion which is framed-up in the subsequent slide.

So consider an adult with (IDD) and multiple chronic conditions. So under the nursing home for a short stay - which is less than 101 days - so it extends

into a six month stay. So this included the required Person-Centered Planning process and ultimately this resident expresses his desire to move back into the community and this triggers a broader home and community-based services transition planning process.

So the questions that we're wanting you to think about in this case, when this is obviously much more complex than just one person inside of a home and community-based services setting, now we're thinking about what happens to this Person-Centered Plan in two types of scenarios: one, it gets complicated by the care domain; and two, by the complexity in individualization of this person.

So first, what is the two Person-Centered Planning processes and here is, pretty clear, that it's the nursing home and home and community-based services. And what are the practice standards and what are the competencies necessary for each and how are those different? How are they different?

Then what are the synergies that could be leveraged to create a single plan that accompanies the transition back to the community and how should these (be) conducted and coordinated and practiced?

Now those are just the types of questions we want you to consider. We're not asking the committee, necessarily, to weigh-in on this individual example but we want you to think about the ones that are most important.

Let's go ahead and go to the next slide. And this is where I'll hand it over to our co-chairs to facilitate this part of the discussion, recognizing that, of course, this does add a much more complicated layer to it but one that we thought that was absolutely critical when we're considering this, so it's

competencies that we want facilitators to have. So (Kristen) and Cheryl, back over to you.

(Kristen): (Thank you for setting that up) (unintelligible). (So I hope that) everybody understands the question that we have, (parts of) (unintelligible) but just as an example that was provided.

But what we're really looking at on these complex…

Gretchen Napier: (Kristen), are you on a speaker phone? We're having a hard time hearing you.

(Kristen): Oh, I'm so sorry. Thank you for (saying that), is this better?

Gretchen Napier: Not yet. I don't know what has changed but you sound distant and almost like you're talking in a tin can.

(Kristen): Okay.

Gretchen Napier: Well let me - why don't you go ahead and facilitate that and let me see…

(Kristen): That's perfect.

Gretchen Napier: …do you want (us to) facilitate this part of the conversation?

(Kristen): For sure.

Gretchen Napier: We're having a hard time hearing. Okay.

(Kristen): Yes, (of course).

Cheryl Phillips: But now that I - now it was great. So this is Cheryl and I think where I'm taking off where Gretchen started. First of all, do you all understand that the question - did we explain it in the context well? The reason for looking at the case wasn't so much to let's case manage that individual case but thinking about the complexities and how that relates to competencies.

So A, you have a competency that we addressed, fully looked at additional complexities and how might we articulate some additional complexities such as multiple settings, et cetera.

So I will pause and first of all see if it's explained well to the committee and then how we might talk about on that deeper layer of competencies, looking at some of these complex and complexing issues.

Amber Decker: This is Amber. I have a quick comment in terms of the Slide 32 that breaks down institutional LTSS, acute in-patient care, HCBS. I'm a little confused as to why institutional LTSS is not - why there isn't an extra circle that just says, "LTSS" since services that are considered long-term supports and services can be provided outside of an institutional setting or should be? And I think that right there is part of the complexity issue is that individuals are having - struggling to access long-term supports and services outside of institutional settings and that's - it shouldn't be an issue that so, you know…

Cheryl Phillips: Yes. So I think that - and I'll raise the question to NQF staff - was home and community-based services presumed to be inclusive of community-based LTSS, separating from institutional settings? Amber, does that get to your question?

Amber Decker: I mean, yes, for sure. I mean that's - I just don't know why institutional and LTSS are married together in this Slide 32.

Cheryl Phillips: So then maybe we should just say, "Institutional - institutional options" or something like that or I see what you're saying. Obviously the institutional part makes it complicated because of rules and regulations and funding sources and all that but you're just saying LTSS doesn't really belong, necessarily, with institutional so I hear what you're saying.

Melissa Nelson: This is Melissa Nelson. I think that the way this section was described did make sense and I think a lot of the core competencies that we've already discussed will apply here also.

One of the areas that comes to my mind that we haven't talked about yet that is even more important here is making sure to bring all the right people to the table and having coordinated communications to try to knock-down the silos.

So I think there is a tendency still for people to think in terms of the nursing home staff, do the nursing home stuff; the community people do the community stuff and I think we do need to find a way to bring everyone at the table at once and get better at how we develop a single coordinated plan for people.

Cheryl Phillips: Yes, yes, excellent point so that a competency also includes knowing who needs to be at the table and making sure that you have a connective process of engaging everybody including the person.

Melissa Nelson: Right.

Amber Decker: (No) and I do think that there should be - this is Amber Decker - I do think that there should be a, in terms of question, what are the synergies that could be leveraged to create a single plan that accompanies the transition back to the

community? To reiterate what the last individual just said, you know, there should be somebody at the institution who is designated to facilitate that and is responsible for facilitating it in a timely manner so that it actually takes place instead of them just saying we only deal with (nurse), you know, institutional stuff. Like I do find that that is something that happens a lot.

Cheryl Phillips: We also have comments from Sally stating that a facilitator must know (his/her) knowledge base and does not need to have all pertinent information but have people included in the plan (who did not) have expertise in all needed areas.

Michael Smull: This is Michael and all good plans answer questions. So what has to be done in advance is to see what questions need to be answered. And the question for somebody who's living in a nursing home who doesn't expect to move would be somewhat different than the question of somebody who was - who is living, who does anticipate or wishes to move. So you'd be adding to the question of who that person is and how they need to be supported into looking at what is their vision of community life and how can we begin to support that.

Cheryl Phillips: (Kari), can you write that?

(Kari): (Fact or comment)?

Cheryl Phillips: So I think this discussion has brought out some new competencies that are related to the complexity that were not necessarily addressed earlier. Any others that come to mind as you think - and part of the reason for having this case was just to put it in a tangible way that most of the call can relate to, what would this look like and what works, what doesn't work and what skills and competencies are needed?

And if we feel like we've captured them fairly well, then NQF staff, are there things that you would like to add or address or question?

Woman 1: Maybe one of the interesting points to discuss would be, sort of, the interaction between the Person-Centered Plan and the shared decision-making, especially when individuals and persons that are moving between say in-patient care and some sort of HCBS setting so when - and requiring follow-up care, of course. So when and how do we marry the two? What are the touch points and what are some of the, maybe, competencies related to making sure that the two are, sort of, travelling together with the individual (slash) person?

Cheryl Phillips: I am - this is Cheryl - so I'm wondering and I'd be interested in the committee's feedback, is this an individual competency of what was just described or is that a gap in our current silo systems of care? So the fact that a Person-Centered Plan in one setting doesn't translate to the next setting or that individual has chosen to transition to, is that an individual competency or really a competency or a lack of competency of the system in which we're trying to navigate?

Janis Tondora: This is Janis Tondora. Unfortunately until the system competencies are in-place and there are any institutions and efforts on a (unintelligible) efforts I think look at some of those (system) - the complexities. But until those things are organized and processed I think remains an individual level competency because (that) - they'll (know how to) navigate the differences across the system.

In some ways it's not unlike what I was saying about the (unintelligible) equal (PO) around a regular (unintelligible) financing accreditation, you know, perspective. And that sense that at the end of this (low-level) there has to be

some degree of (concert) and competency around navigating what I think everyone recognizes is a far from ideal system currently so I think it's a bit of both,…

Cheryl Phillips: Okay. Thank you.

Janis Tondora: …personally.

Amber Decker: So what is - this is Amber Decker - wouldn't the practice standards be, you know, capturing their needs and their wants in both nursing homes and HCBS settings I mean regardless of where they're located?

Sally Burton-Hoyle: This is Sally and yes, absolutely. Absolutely what they want; what they'd like to do; what their interests are; what their needs are -- those things absolutely matter. Michael Smull brought up something - I turned it in a different way - that prior to the Person-Centered Plan, a pre-plan should be done so that the questions, as he talked about, would be addressed and that the correct people were at the meeting. Without having that, it's usually a big waste of time regardless of somebody in that, you know, (dually) integrated, whichever of the systems that are talked about. But Amber, yes, I agree wholeheartedly with what you said.

Michael Smull: This is Michael. The - just to make it even more complex, what we've learned as we've helped people move from institutional settings to community settings is what matters to the person in an institutional setting is frequently different when they move to a community setting that the restrictions on choice produce distorted pictures of what the person wants and desires. And when they have an opportunity to move and experience a broader array of choices and more control over their lives, then what is important to them also change.

So that while you could say there would be one plan to initiate the move, people need to keep listening in a very acute way during the move and as people settle.

Cheryl Phillips: Yes, I think - this is Cheryl - that's critically important. Thank you. Yes, it's not like we have done a one-and-done, here's the plan, we've listened to the person, we've moved them to a new setting. But now the need is to question the care planning may take on an entirely different direction and level and new issues come forward. And if we just make the assumption that we're already executing the Person-Centered Plan without checking back in, we will completely miss what it is the needs that are driving that individual. Very good point.

Amber Decker: So I'm just curious if we need to add to this as a core competency? It sounds like this is very dynamic and very much a living document and process and way of really understanding the unique person. Is that part of our core competency is adding something around being dynamic?

Cheryl Phillips: I would - I would think so. It sounds like that's what's being said and also on acknowledging that needs will change with changing situations, changing environments. There may be a variety of reasons that will drive change for the person and so that that dynamic care plan is reflective and is not static.

Kate Buchanan: Cheryl, this is Kate. We have a couple of comments submitted through chat.

Cheryl Phillips: Great.

Kate Buchanan: And one is from (Carol Barnett). "A Person-Centered Plan is a living document and only owned by the person. It is important that no matter the method of service delivery that the document must flow with the person."

And then we received another comment from Pat. "In some circumstances, the facilities really constrain decisions when the person really wants to go. The decision-making should be supported for what the person wants and the problem-solving proceeds from there."

And those appear to be the comments.

Cheryl Phillips: Okay.

Glenda Armstrong: This is Glenda Armstrong and I have some, sort of, the same concerns as the last comment in that it seems that our competencies around the real complex issues assumes that everyone around the table is in support. In reality, and maybe it speaks to the silos, there is often a lot of resistance when you make those transitions from folks that work, and even family, from the institution to their community and how can people resolve their fears and their prejudices and their preconceived notions about what that means, this is truly a skill set. It's negotiating the resistance and the barriers.

Kate Buchanan: Thank you.

Cheryl Phillips: And for those - and thank you, Glenda also for speaking. As we look at the list, there are a few people that are offering very helpful comments. We certainly appreciate them but we want to make sure that those voices who maybe haven't said as much are also given a chance to speak up. So if there's anybody who hasn't been sharing so far, or as much, if there are additional

issues that you're just sitting on and saying, "Oh, man, I wish could have a chance to say something," please do.

Denise Myler: This is Denise Myler. Can I ask a stupid question? How many silos are we looking at that they need to be broken down in one way or another? Do we have an idea that somebody could send us a list of?

Cheryl Phillips: Well I think going back - and I don't have the slide numbers in front of me, let me see if I can see - NQF staff has started with the assumption of settings of care. We talked a little bit about that at the beginning and whether or not we captured all the settings. I'm not sure that there is every single possible construct that…

Denise Myler: Page 24, 25.

Cheryl Phillips: …yes, I think we have the broadly stated. So if there's something that you think is missing, we absolutely would like to include that.

The Slide 24, 25.

Denise Myler: Yes.

Cheryl Phillips: Okay. (I think) you all have to think about this.

Woman: Yes.

Cheryl Phillips: So representative settings and representative services were the two slides. And even in those I can see some areas where one might do some lumping, you know, so institutional setting may include the assisted living; it may include long-stay nursing homes…

Amber Decker: Long-term care setting might be the - I mean institutional is very - I was a little confused by it, honestly.

Cheryl Phillips: Yes, I see where it, yes.

Amber Decker: (Identifies). Or I'm not sure why it's called institutional. I don't know if maybe it should be called - I think institutional should be in the light purple area somewhere and then the LTSS or LTC should be its own area because long-term care is a big thing. It's a, you know, it's services are around it.

Cheryl Phillips: And in fact, many might say that assisted living, for example, fits under a long-term care model, yes.

Gail Fanjoy: Gail Fanjoy. I think that institutional is a way of life, not necessarily a place. I just put a comment in the comment box but there are many people, including (being in group) hones and being captured during the daytime by agencies that are, you know, not considered institutional. As a matter of fact, they're probably getting HCBS funding for those services but a person can feel very institutionalized within those places.

Cheryl Phillips: Right.

Amber Decker: And I - I'm sorry, this is Amber Decker again. I just wanted to say that I do think educational settings, you know, and there's a lot of them, should be somewhere on this list.

Kate Buchanan: And we received a clarifying comment from our colleague Pat. "Institutional is defined by the settings rules. Those are the categories that meet HCBS settings rule." So Pat (just wanted to)…

Cheryl Phillips: Okay.

Kate Buchanan: …provide clarification.

Cheryl Phillips: Thank you. Any other thoughts? We have, I think, explored some of the complexity questions. We've looked at added competencies. We've looked at settings and services. And I have the idea of adding educational settings so school settings, a variety of educational settings I think is a valid one particularly for younger individuals.

Sam Stolpe: Yes - Hi, this is Sam. And there's been a number of really great points that have been made about what occurs when people transition between settings. Maybe we should also spend some time thinking about the complexity and sort of, the skill sets that are needed when we're talking about complexity of (integrated tools) and the - so the care they might need and the, sort of, increases in competency that we might expect someone who is facilitating persons that are planning to have so just some examples of some of the competencies specific to complexity in care settings that have been brought up so far.

So it was mentioned that these individuals who are facilitating need to understand that restrictions on choice brings distorted views of what persons want and desire so that means that a core competency was implicit to that as that they need to understand how restrictions limit choice and distorts viewpoints.

And then we also had one around dynamics in complexity in care settings, just having an understanding of that broadly.

But maybe some specificity would be helpful for the group too. Is - so if we said to create categories by which we can generalize things and hence we have these labels between HCBS and institutional settings - and sorry if that has (engendered) in the confusion - but we were just trying to pick things that made sense from some of the (vocabulary) that is used instead of statute and would be easily trackable by the committee if we'd listed out the care settings because that's really what we're trying to get to is what happens when someone transitions from one spot to another.

So if we were to ask just specifically, what kind of core competency shift needs to occur if someone's moving from HCBS to one of these, what we've described and forget the (term if that doesn't say) what's the best term, moving from an HCBS type setting into a long-term care setting? Like what needs to happen to the plan and what kind of skills someone facilitating the plan would need to have in order for that - the thing that needs to happen to a plan to occur?

Amber Decker: Well, this is Amber Decker. I would imagine that if you're talking about moving from HCBS setting to a long-term care setting that there would be some change in terms of what the plan would be capturing, what is allowed to capture and what's already built-in.

For example, if you go someplace and they already have the thing that, you know, you have been utilizing outside of that setting. If it's already built-in or not, then it (won't) necessarily be included.

You would have to have knowledge about where the individual's moving to and what they have there already.

Cheryl Phillips: Right. What do other people think about the complexities, if they're moving, specifically, from home and community-based services to…

Janis Tondora: This is Janis Tondora. I just wanted to pick up on something - I think it was Sam - that you were saying in this first part of your conference which is the importance of considering this complexities (for the) individual person they present in part and circumstances and the idea that what does it mean to be Person-Centered and support Person-Centered care and planning in the face of what might be potential restrictions or restrictions that are (increased) either because of (unintelligible) (orders or course of emergency) (unintelligible) situations.

And you know, you have just as much of an obligation to be as front-and-centered as possible in those circumstances and our obligation (to see that), you know, doesn't evaporate in those moments.

So I think some kind of a core competency around recognizing (are we - do) we know when our (unintelligible) (using) are very, sort of, best practice. (Unintelligible) in behavioral health recovery or in just (unintelligible) strategy meaning how do we make sure that people have, hang onto this (unintelligible) (economy) around this.

And this is (unintelligible) at a time when perhaps there could have been a (HCBS) safety concern, a temporary - and this is not a temporary (period) (unintelligible), (they might) need to see some (of the systems in-place).

And equally important, a critical process is recognizing that if (restrictions on programs and treatments) are in-place, they're not intended to be permanent. (And too often) the restrictions that are put in-place really end up being (in-place) for the long-term. (But I see it), is it a critical competency in those

complex situations to recognize when people are stepping in for a particular (reason)? (It's a step) in the right way; (a successful) (unintelligible) and (there's no one to step out).

So I just wanted to, you know, elaborate on that (unintelligible). So thanks Sam for adding your…

Amber Decker: This is Amber Decker. What about advanced care directives or psychiatric advanced care directives?

Woman 2: Exactly. That is exactly…

((Crosstalk))

Amber Decker: Any other…

Woman 2: …the (unintelligible).

Amber Decker: …I mean could - maybe there should - maybe that should be included in the core competencies so that more individuals actually have those things than not.

Woman 2: But I think probably the latter.

Cheryl Phillips: Yes, that's the exactly the kind of - when I think of our best practice (unintelligible), you know, these are things that people have a legal right to complete yet it's still, you know, an alarmingly (few) number of people, both practitioners and people (served aren't aware of) and it's exactly the kind of thing that allows people to hang onto to some (unintelligible) of decision-making when (unintelligible) might have to be (taken away).

(So that just) (Unintelligible) Amber that I'm (thinking I want to make those remarks).

Woman 2: Yes.

(Kelly Britton-Wale): This is (Kelly Britton-Wale) and I guess want to add-in. I feel like we've skipped a level and we need to go back to the facilitator doesn't need to know everything. And in fact, they need to bring in people trusted by that individual and approved by that individual who can offer that expertise.

And we're kind of, you know, we're going at all these different directions without going back to that person and saying, "You said you wanted to do this or your behavior is communicating you want to do this." You know, "How about this person or that person? Is that okay if they come and help us?"

And rather than going ahead to being (directive), I think we just keep moving away from what the individual might want.

Amber Decker: What - I'm sorry, this is Amber Decker. The only reason I mentioned those things is because a lot of the times when an individual is moving from a - from the communities into a more restrictive environment, those things are missing and they're looked for. And because they don't have them in-place, some of the services and things that are important to them aren't captured. So I'm sorry if that - if, you know, I wasn't…

(Kelly Britton-Wale): No, I'm not…

Amber Decker: …trying to suggest that.

(Kelly Britton-Wale): I agree with you. Those things need to be there. But all too often in plans, we do all these things and we bring in all these people and what we do is we (leave) the person - the person we're doing the plan for, they're just - they're lost. All these people are coming in and it's like what - this isn't even about them. It's about other people doing their thing.

So I think we need - we need to be cognizant of that and the group composition and the approval of the individual of those people.

Kate Buchanan: We received a comment from committee member (Carol Barnett) saying, "That there are complexities throughout the process, both when transitioning and when (not to transition when) services or (abilities) change. It is important that the competencies are not situation-dependent."

Michael Smull: This is Michael Smull. There is also - and I think this was referred to earlier with the idea of best practice - if I'm working with somebody with dementia, it's helpful for me to know what sundowning is. If I'm working with somebody who has a label of having challenging behaviors, it's helpful for me to recognize the impact of trauma and behaviors that may reflect trauma rather than simply non-verbal critique of the services I'm getting.

Kate Buchanan: We also received a comment from Pat Nobbie discussing the core competency of resourcefulness and sensitivity. "This adjustment is difficult; people may be giving up a home, belongings, relationships. But if it is unavoidable, then acclimating a person, visiting, making introductions, assuring support, bringing personal items, et cetera, is sensitivity."

Cheryl Phillips: (Really, really) like that one.

Kate Buchanan: "And negotiating conversations with staff to assure accommodations." So that's the comment from Pat.

Cheryl Phillips: All right. Who else wants to weigh-in on all the things we've talked about today?

If not, I think…

Michael Smull: This is Michael Smull again.

Cheryl Phillips: …so yes, Michael.

Michael Smull: I just wanted to say it's very difficult to separate Person-Centered Planning from Person-Centered Practices. Person-Centered Planning doesn't matter if there are no Person-Centered Practices that are supporting it. And it could - outside of the - (their view) in some ways is one of those issues that keeps coming up when we talk about implementation or even when we're talking about how do we learn about what matters to somebody.

Amber Decker: This is Amber Decker. I just wanted to say, again, that I do think - thinking of it as a service is important just the way teaching is a service because it reflects the need to have individuals that are willing to serve and provide, you know, versus just mark down the list.

Cheryl Phillips: Well I think all excellent points that sound like they're good closing points. Are we ready to transact to NQF and then open up for public comment?

Kate Buchanan: Thank you so much, Cheryl. This is Kate with NQF. So we have had many, many public comments received through our chat. I've been at NQF for a

number of years and I don't think I've ever seen so many wonderful comments.

So one of the things that I want people to know is all of these comments are available to staff. We are reading them; we are thinking about them. But in the interest of time, we actually can't, right now, go through and read all of the ones we received in the 2-hour duration allowed.

So we really want people to, you know, based on the reflection they've had to-date, do one of two things depending on what's easier for you. One is to verbalize - (participate) verbally on providing some comments. And the other is to, you know, moving forward, we'll be reading the chat function.

So if there is (summation) comments or if there are just some things that you would like to highlight, we will be looking at all the comments you've sent previously.

But just for the ease of us facilitating public comment, there are additional general comments or specific comments that you would like to have, we will start reading from the chat function starting now.

So we either encourage you to chat them now or to say them aloud and to unmute yourself. It is star 7. So we will be doing both right now. So we - opening it up to all public comment. So either star 7 to unmute or to start typing. Please note that everything that has been typed so far will go to staff for our consideration. And you know, we - and we really appreciate them.

(Jenn Otesky): Hello?

Kate Buchanan: Yes.

Cheryl Phillips: Yes.

(Jenn Otesky): Hi. My name is…

Kate Buchanan: Hello?

(Jenn Otesky): (Jenn Otesky).

(Judy Stagnam): Hello?

Cheryl Phillips: Oh, hi.

(Judy Stagnam): Yes, this is (Judy) from Wisconsin and I…

Cheryl Phillips: (Unintelligible). So, (Judy), I think we have one speaker. Let's go ahead with the woman who was speaking and then we'll take you next (Judy).

(Judy Stagnam): Okay.

(Jenn Otesky): Hi, I'm (Jenn Otesky). I'm sorry, I think I interrupted but I am impressed with what you're discussing and I think it is somewhat of a challenge regarding if - when you were discuss - I think long-term care is a better way to look at it.

I'm a (unintelligible) ambassador and have been involved with (unintelligible) as a public town member or patient panel member-consumer and I think in the right direction. There's a lot of work to do so I look forward to - I don't know if we are able to read some of the comments on the public and if that's available I will do that.

So I just wanted to thank you for what you are doing and it's a big job going ahead and I just want to comment on the recovery. It is important for some people, there is recovery. It doesn't pertain to everybody but some people it does so I'm glad that you added that in there. Thank you and have a great day.

Cheryl Phillips: Thank you. And so (Judy) from Wisconsin.

(Judy Stagnam): Yes, hi. This is (Judy Stagnam). I'm a nurse consultant from the Wisconsin Department of Health Services. And again, I want to echo what the individual just before me said that I think is really great work and especially in light of the HCBS settings rule and the importance that CMS is going to place on the Person-Centered Planning goal.

And I've heard people talk about focusing on the individual. I've heard talking about collaboration and coordination and also the ability to generalize some setting-to-setting. And then looking at the competencies and seeing them as identified more as skills, I couldn't help but start to think about well, if maybe we have an opportunity here to, kind of, set an example by indicating that our competencies are going to be written or composed from the Person-Centered perspective versus from the professional perspective.

And to do that you almost have to think about what will be the outcomes? What the competencies reflect, outcomes - desired outcomes versus skill sets.

So I kind of throw that out there for consideration because I'm also thinking that if we think of it that way, that when we get to the point of trying to discern the measurement, the Person-Centered Planning measurement, we

might already have a foundation for what we want to measure and how we would want to measure it.

Likewise, if we think about outcomes, that we've got the person at the center, it becomes less maybe (unintelligible), if that's the right word. It becomes less idiosyncratic in the sense that we don't think about, okay, they're in this setting so this - these rules apply. They're in that setting, these rules apply. But instead we're really focusing on that individual and what competencies should the facilitator be thinking about in terms of outcomes for that individual.

And I heard (Carol)'s comment about the competencies not being situation-dependent so, like, that's kind of a dovetail off of that as well. Thank you.

Cheryl Phillips: Thank you.

Kate Buchanan: And Cheryl, this is Kate, we have several comments in the chat function that I can read. One is from (Kelly Nesbitt) saying that, "There needs to be recognition and the recognition of an accommodation made for those who need a higher level of support to make decisions related to their lives. The support the person needs must be recognized and honored. There are times when Person-Centered means another person verbalizing what they believe the individual wants and desires (unintelligible)."

We have a comment from (George Stiffos) saying that, "Service is power over, we do not want - we do not support without serving."

(See) two comments from (Mary Bishop). "Person-Centered Practices Planning and Thinking needs to be a human right. We need to have a federal mandate to flow across funding streams and in silos. Supports and services

should flow across the continual of life and planning should be the same across programs and funding sources that allows the planning process, in itself, not to separate but be as smooth - be smooth when there is a change in conditions, the person changes their mind and wishes to change his or her plan."

We have several more comments. We have one from (Sandra Sellenger). "I would encourage the committee to think about how the topic of Person-Centered Planning can be simplified so it is easily understood for the individual caregiver organization. Trying to retrofit something within an already complex health system will create an equally complex solution."

From (Nicole LeBlanc) we have - oh, sorry, thank you very much for your (resources), (Nicole). I saw that text. And right now, those are the - that's it for the comments we received in the chat function.

Denise Myler: Kate, this is Denise Myler.

Kate Buchanan: Yes.

Denise Myler: Could those comments that you have received, both in the chat box and that were expressed on the phone, could you please send those out to the committee members? I would like to see those.

Kate Buchanan: Yes, Denise, that's a great point. So one of the things that we are going to do - and I neglected to mention so thank you for bringing that up - but we're going to download the chat function so that it will - we'll be able to share what everyone suggested and commented. We will share that both with the committee members and when we post our transcript, we will be - also be posting the comments that we received onto our Web site. So we will be

sharing with the committee, further, those comments that we posted onto our Person-Centered Planning Web page.

Denise Myler: Thank you.

Cheryl Phillips: Any other public comments that would like to be shared? We have a few more minutes and we want to respect everybody's opportunity to speak up if they would like.

Kate Buchanan: Yes, we actually - I, Cheryl we received some in the chat. So we received another from (Mary Bishop) saying, "Until (utilization) review and monitoring occur as rewards for use of Person-Centered Practice (and reported) to the planning process, we cannot see this heavy lift."

(Tammy Ifflod) said, "We should focus equal effort and time on supporting individuals to have a voice to leave for their own (needing) in whatever way that looks like to that person."

And then we had our own committee member, (Dory Tempio) say, "It is a human right and individuals, not cases, but people should have consume choice and control."

Cheryl Phillips: Anyone else want to make a public comment verbally? If not, we - I know we're a couple of minutes ahead but maybe it's a good time to move to Next Steps. We can do one more check. Anybody on public comment wish to share something that they haven't already shared remembering that all of your written comments will be read and shared with the committee.

Kate Buchanan: Actually, Cheryl, we just got a couple more.

Cheryl Phillips: Okay.

Kate Buchanan: And so from - one more from (Mary). "(Please), I wanted to address (deployment) of education."

(Tom Keating) provided a comment that, "Problems with implementation and transition across settings have been discussed why these problems being understood in terms of why there is a breakdown and whether there is some tension between the notion of Person-Centered Planning as a meeting slash visionary activity (versus) an ongoing process. And if the latter, where does the responsibility lie for the (unintelligible) who (are on) the plan?"

And we received a comment from (Mary) and just - and (Mary) feels that, "The consumer voice was - that some of the consumer voices were dismissed in the first webinar, that this would be counterintuitive to any interest in Person-Centered Planning. This needs to be addressed." (Mary), I can speak on behalf of - and to our staff - to apologize, (unintelligible), if that was your experience.

You know, one of the things that we've been doing, and in constant communication with, is making sure that we have self-advocates and consumers participate in these meetings. We do have liaisons that we will be appointing for the next Web meeting so deep apologies for that and really want to say that all voices are respected here and heard and that all comments are going to be shared with the committee, staff and the public.

And Cheryl, I think that - that's all we have right now in…

Cheryl Phillips: (Unintelligible).

Kate Buchanan: …in the…

Cheryl Phillips: One last check-in. We'll pause. I'm not hearing any. I think we can transfer back to NQF staff and Next Steps. Thank you. And thank you all for the public comments as well, both written and verbal.

Yvonne Kalumo-Banda: Thank you so much for those comments and this - for the discussion that we had today. So next I'm just going to share on the Next Steps. So we, as NQF staff, we use all committee recommendations and those that have been provided by the public to further expand their (unintelligible) of core competencies for individuals that (were performing) Person-Centered (unintelligible).

Our next committee meeting will be on July 31. And during this meeting, NQF staff will present a draft list of core competencies for which we will expect the committee and the general public - public commentary to give their input weigh-in and feedback.

Listed on your screen are the contact details to reach out to us. We have the project email box that is listed there. Expect a response to your email within 48 hours. Next listed is the telephone number if you would rather call-in to speak to us.

We have also listed the project page which is on the home page of the NQF page. However if you select that link, it will take you directly to the Web page where you will find the resources for the project itself, (Meeting 1 and 2) and any other meeting information as it is developed.

This SharePoint is available to our committee members and there you will find meeting materials that will be posted as well as those being added to your calendar invitation.

We would encourage the public to subscribe to the Project Alert subscription. That way you're made aware of our meeting dates and when - and as meeting materials are posted online.

Kate Buchanan: And that is - that is all we have. So we greatly appreciate everyone taking their time to participate. Just so everyone knows, the audio recording as well as the written transcript and the comments will be posted onto the (press) Web page in about a week following this meeting so that that will be a resource to everyone.

We really appreciate everyone taking the time. And as things come up, as Yvonne said, please contact us -- email, call -- we really appreciate everyone taking the time.

So with that, we can wish everyone a happy rest of their Monday.

Cheryl Phillips: Thank you all.

Woman: Thank you.

Woman: Thank you.

END