**Community Connections**

Pay for Performance 2023

Community Care Individual Plan

Individual MCO Proposal Submission Part 2: C, D, and E – FINAL 9-2023

This document contains individual MCO responses to the sections in the Community Connections Part 2 that DHS requires each MCO to submit a separate response. Only the questions that require an individual MCO response is contained in this document.

Table of Contents

1. [Part 2C.4: Include Q1 2022 utilization data report and data source for each category.](#_4._Include_Q1)
	1. [Part 2C.4.c.i.ii.iii.: Summarize Data Components](#_c._Summarize_how)
2. [Part 2C.7: Summarize the MCO’s current practices regarding community connections including valued social roles.](#_7._Summarize_the)
3. [Part 2C.9: Provide current barriers for each MCO and their stakeholders and partners around implementing the community connections activities.](#_9._Provide_current)
4. [Part 2C.14: Develop SWOT analysis for each MCO to determine their strong points, weak points, biggest opportunities, and largest threats to the Community Connections initiative.](#_14._Develop_SWOT)
5. [Part 2D.3.4: Strategic Plan for Community Connections and Changes in Practice](#_Part_2D:_Strategic)
6. [Part 2D.5.a.b.c.d.i: For each objective, summarize the implementation tools and/or systems that will be utilized.](#_For_each_objective,)
7. [Part 2D.6.a.b.c.d.e: Summarize a sustainability plan for continued improvement toward meeting the vision of this initiative beyond the 5-year cycle.](#_Summarize_a_sustainability)
8. Part 2E.1.a.b: Training and Technical Assistance Plan (separate attachment)
9. [Part 2E.4.a.b.c: Training method and documentation](#_4._For_each)
10. Appendix 1: Supplementary Member Exploration Questions for Community Connections
11. Appendix 2: Community Asset Mapping Tool

# Part 2C: Preparing for Strategic Plan Development

## 4. Include Q1 2022 utilization data report and data source for each category.

## a. Report the following data categories as utilization per 100 enrollees.

## i. Non-Institutional Living:

## a. Members in own home or apartment;

## b. Members receiving supported home care;

## c. Members in residential settings (provide utilization data for each subcategory);

## a) 1-2 Bed AFH

## b) 3-4 Bed AFH

## c) CBRF with less than 8 people

## d) CBRF with more than 8 people

## e) mRCAC

## ii. Institutional Living:

## a. Number of members in SNF (nursing home)

## b. Number of members in Centers (FDD/ ICF-IDD)

## iii. Daytime Services:

## a. Prevocational services community-based;

## b. Prevocational services facility-based;

## c. Daily living skills training – home and/or community;

## d. Adult day care – facility based;

## e. Consumer education and training;

## f. Day habilitation services;

## g. Counseling and therapeutic resources; and

## h. Transportation – community specialized non-medical.

## b. Report the total expenditure amount for CY 2022 for:

## i. Non-Institutional Living (total for all settings listed in 4. a) i.).

## ii. Institutional Living (total for all settings listed in 4. a) ii.).

Below is a table with the data for this section for Community Care. Encounter utilization data was provided for Q1 2022. Figures below represent the number of members per 100.

|  |  |
| --- | --- |
| a.      Report the following data categories as utilization per 100 enrollees.  |   |
| i.            Non-Institutional Living: |   |
| a.      Members in own home or apartment;  | Family Care: 51 / Partnership: 43 |
| b.      Members receiving supported home care;  | Family Care: 32 / Partnership: 27 |
| c.       Members in residential settings (provide utilization data for each subcategory); |   |
| a)      1-2 Bed AFH | Family Care: 2 / Partnership: 1 |
| b)      3-4 Bed AFH | Family Care: 14 / Partnership: 21 |
| c)      CBRF with less than 8 people | Family Care: 5 / Partnership: 5 |
| d)      CBRF with more than 8 people  | Family Care: 16 / Partnership: 15 |
| e)      RCAC | Family Care: 6 / Partnership: 6 |
| ii.            Institutional Living: |   |
| a.      Number of members in SNF (nursing home)  | Family Care: 7 / Partnership: 15 |
| b.      Number of members in Centers (FDD/ ICF-IDD)  | Family Care: 0 / Partnership: 0 |
| ii.            Daytime Services: |   |
| a.      Prevocational services community-based; | Family Care: 0/ Partnership: 0 |
| b.      Prevocational services facility-based; | Family Care: 4/ Partnership: 1 |
| c.       Daily living skills training – home and/or community; | Family Care: 0 / Partnership: 0 |
| d.      Adult day care – facility based; | Family Care: 2 / Partnership: 8 |
| e.      Consumer education and training; | Family Care: 0 / Partnership: 11 |
| f.        Day habilitation services;  | Family Care: 7 / Partnership: 3 |
| g.      Counseling and therapeutic resources; and | Family Care: 8 / Partnership: 16 |
| h.      Transportation – community specialized non-medical. | Family Care: 13 / Partnership: 6 |
| b.      Report the total expenditure amount for CY 2022 for: |   |
| i.            Non-Institutional Living (total for all settings listed in 4. a) i.). |  Family Care: $102,010,077 / Partnership: $7,639,249  |
| ii.            Institutional Living (total for all settings listed in 4. a) ii.). |  Family Care: $16,450,945 / Partnership: $3,313,647  |

## c. Summarize how and which data components, and any other baseline data, will be used in your planning process and/or incorporated into developing baseline measurement to increase member’s Community Connections while successfully implementing the Strategic Plan.

* 1. how you may further utilize the encounter data related to community connections, as some services may have a community-based component/activity already built-in that is not visible in current encounter data review. Some existing authorized services may be effective in increasing community connections, as is, or by making modifications.

Community Care will utilize the encounter data to identify which settings and activities already exist that can seamlessly support Community Connections. This includes a review of existing services that are currently supporting or could support additional community involvement for members. Community Care will then use the most relevant data sets for the proposed cohort in the first year and to the added cohorts during the remaining P4P years to further assess current community connections and additional opportunities that may exist.

Examples of the data that may be used include:

* + - * + Members in own home or apartment,
				+ Community-based prevocational services,
				+ Daily living skills training in the home or community, and
				+ Consumer education and training services.

For example, 51 members per 100 in the Family Care program currently reside in their own home and apartment. However, it appears less than 35% of FC members are utilizing the services listed.

As discovered in the Meaningful Activity survey, transportation and awareness of community offerings were among the top three barriers of engagement. Within our own encounter data, we see only 13 per 100 of FC members were utilizing transportation services in the first quarter of 2022, and all other services were utilized at a total rate of 21 members per 100, which supports this sentiment.

Encounter data can be used to assess the efficacy in reducing these utilization barriers. For example, members who have indicated stairs/exits as a hindrance to transportation, we may wish to compare authorizations for ramps/accessible transport services with observed encounter data and evaluate any discrepancies. Encounter data alone is limited in what it can provide i.e, if members now have access to entry/exit, but still low transport utilization, this could simply be due to friends/family providing this service outside of our encounter system. Therefore, emphasis on the need to couple encounter data with care team knowledge/feedback.

In another example, 43% (or 43 members per 100) currently reside in a residential setting which may have community based component/activities built in.

Utilizing this data will allow Community Care to provide some direction and information to IDTS so that they can have conversations with members about any current involvement in the community, what other activities they would like to pursue, and any barriers to participation and develop goals for the care plan. Within that plan, Community Care will identify any natural or paid supports that may play an important role for a member who wants to maintain or increase their participation in community life.

* 1. how the MCO evaluated natural supports to effectively integrate natural supports into the Strategic Plan.

Evaluation of natural supports during this strategic plan creation period was via feedback from members and information included in a member’s record. Community Care was able to get a broad scope of natural supports for our members but to gather how they are supporting each member and in what capacity, was not something Community Care was able to do within the time period provided. Community Care will continue to further assess the availability of natural supports via the person-centered planning process and documenting how natural supports can be utilized to increase community connections for members.

* 1. if the summary indicates that the MCO cannot evaluate the effectiveness of natural supports, include how that information will be obtained and incorporated into the Strategic Plan.

The use of natural supports as it relates to Community Connections will be evaluated as part of the assessment tool and the development and review of care plans. Where natural supports exist based on a member’s desire and the natural support’s willingness, the IDTS will discuss ways these natural supports can assist the member with their desired community involvement. When natural supports are identified and active, their involvement will be added into the care plan and evaluated every six months to determine whether the use of natural supports is successful. Where natural supports do not exist, this will be explored based a member’s desire and the appropriateness of utilizing these supports to facilitate community involvement. The use of natural supports related to Community Connections will also be a regular discussion in monthly ongoing IDT staff communications with members.

## 7. Summarize the MCO’s current practices regarding community connections including valued social roles.

Community Care has several ways to assess members and develop plans that allows members to engage in community activities and find valued social roles. The following are the questions that are asked of members during the assessment process, all of which are related to community integration, participation and identifying the barriers that may exist to become more active in community life. These questions give IDTS an understanding of what members may be interested in, their current relationships, their communities and strategies to support members in their goals.

The Care Management Assessment includes the following questions/information:

* Describe member’s current relationships with family, friends and natural supports
* Is Member satisfied with current spiritual lifestyle?
* Describe a typical day.
* Does member have opportunities to do things that are important to him/ her?
* What kinds of things does the member like to do when they go out of the house?
* Is member getting out in the community as much as he/ she would like to?
* Describe any accommodations/ assistance that may be needed in the community
* Is there a concern for member’s overall safety when alone or in community due to decision-making skills?
	+ If yes above – describe concern and support provided
* Describe any member strengths related to Social or Community Integration
* What is most important to the member related to Social or Community Integration?
* Describe any long term care outcomes related to Social or Community Integration
* Are there risks identified in the area of social or community Integration?
* Does member drive?
* Member has access to a vehicle.
* Describe concerns with member driving (if any)
* Member is unable to or does not drive
* Family/ caregiver/ friends are available to assist with transportation
* Able to ride in a regular vehicle
* Requires adapted vehicle
* Able to use public transportation
* Able to utilize transportation options independently
* Needs attendant with him/ her for transportation
* Needs assistance with finding/ arranging transportation
* Other transportation assistance needed (please describe)

The following are questions/assessment are part of a Home Safety Assessment utilized in another program that could be utilized to address any barriers to community access:

* In the past year, how often has the availability of transportation been a problem for you?
* Member identified or observed barriers to transportation
	+ Stairs to exit home
	+ No/ inadequate DME
	+ No accessible vehicle
	+ No caregiver to assist
	+ Can’t tolerate ride
	+ Other
* In the past year, how often has the design and layout of your home made it difficult to do what you want to do?
* Member identified or observed barriers to home layout
	+ Inaccessible bathroom
	+ Indoor stairs
	+ Lacks DME
	+ Narrow pathways/ doors
	+ Other
* In the past year, how often has the natural environment made it difficult to do what you want or need to do?
* Member identified or observed barriers to natural environment
	+ No access to snow removal
	+ Inaccessible driveway/ sidewalk
	+ Inadequate plumbing to complete I/ADLs
	+ Other
* In the past year how often did you feel unsafe in your home or neighborhood?

In addition to these specific community integration questions, our RN, NP and other specialty assessments focus on the member’s physical impairments or functional issues, pain, ADLs needs, and psychological diagnoses that could limit or require some sort of intervention for members to access community resources.

Within the Member-Centered Plan, each goal developed with the member has a category, many of which will apply to enhancing community connections and community life in general. These goal categories include:

* Health related
* Functional
* Living Environment
* Community Integration
* Employment
* Self-Determination (SDS)
* Financial
* Other

Community Care has not had a formal process to measure community integration or community connections as an outcome for members. Therefore, Community Care does not have any current data suggesting that the questions and tools used above are increasing a member’s engagement in community life. Through the outcome measures designed as part of the Community Connections P4P, Community Care will need more time to establish baseline data for current members’ involvement in and satisfaction with community life. Utilizing this baseline data will then allow Community Care to determine strategies related to maintaining and/or increasing involvement and satisfaction with community connections.

## 9. Provide current barriers for each MCO and their stakeholders and partners around implementing the community connections activities.

​ Below is summary of current barriers identified for Community Care.

At minimum, provide a barrier summary for

1. **members;**
	1. Members expressed that the following were barriers to being more active in community life:
		1. People with active addiction or chronic mental health issues will have difficulty participating because they are focused on the hierarchy of needs.
		2. People with criminal histories will find it difficult to find jobs or participate in community activities, even if the history was many years ago.
		3. Having/maintaining a car is expensive if you need one because there is not good public transportation.
		4. The quality of transportation companies is not that great from a member experience.
		5. Guardians or other family members may not agree to or support member involvement in the community due to risk of harm or illness.
2. **the community;**
	* 1. Rural areas do not have as many activities as urban areas.
		2. Transportation is a barrier is some areas without bus lines.
		3. Many community activities require a fee that some members may not be able to afford.
		4. Not all places are accessible to persons with disabilities.
		5. Some communities are afraid of or not accepting of individuals who appear “different” or appear to have a lot of needs or an undesirable background.
		6. Communities may not have the financial resources to design and build inclusive and accessible communities.
3. **service providers of day services, adult day care, daily living skills training, and residential care;**
	* 1. Staff shortages in many facilities make it challenging for individualized care.
		2. No additional funding to address staffing shortages.
		3. Facilities are challenged in getting members to their general appointments like doctors and dentists.
		4. Facilities don’t have the staffing ratio structure to allow for individualized community activities when four members want to go to four different places at the same time.
4. **MCOs**
	* 1. Members who commit to a goal to increase participation but do not follow through with actions to achieve the goal.
		2. Having to utilize an outdated functional screening tool to determine a reimbursement structure that could be a barrier to funding community activities.
		3. Contracts are built with so many compliance pieces that IDTS have difficultly managing the current expectations. Adding more to the contract without reducing caseloads or compliance requirements will be challenging.
		4. There is a disconnect between the MCO’s responsibility and liability for member safety and Community Connections practices that propose more member independence, possibly posing a risk to the member or the community. This plays out mainly with MCO auditing entities where MCOs are seen as responsible for everything related to the member vs. empowering the member to be more independent.
5. **Family Care/Family Care Partnerships Program**
6. Finding the balance of addressing risk and safety as priorities and promoting more independence with Community Connections.
7. MCO liability if a member poses a risk to themselves or others in the course of their increased participation in the community.
8. Additional DHS oversight activities still exist so the capacity to ensure Community Connections is prioritized moving forward.
9. There is a disconnect between the MCO contract related to utilizing paid supports and the Community Connections practice that looks to develop more natural/unpaid supports. Ombudsman groups are advocating the use of paid vs. natural/unpaid supports.
10. Vendors/providers following up timely with requests, needs for equipment by MCO or member to facilitate a community connections goal.

## 14. Develop SWOT analysis for each MCO to determine their strong points, weak points, biggest opportunities, and largest threats to the Community Connections initiative.

Below is Community Care’s SWOT analysis for the Community Connections initiative. To complete this SWOT, input was obtained through conversations with IDTS, the Community Care Community Connections Steering Committee, various program leaders and support staff (i.e., quality improvement, information technology, learning and development, provider relations and finance).

|  |  |
| --- | --- |
| **MCO** | **Community Care, Inc.** |
| **Strengths** | **Weaknesses** |
| * Some members are already active in the community
* Members who live with family or natural supports have supports to help them get to places
* Members who are in close proximity to places like a community or senior center tend to be more active
* Members with access to bus passes and bus lines tend to be more active
* Community Care has specialty departments who can help find creative ways to overcome barriers, rehab and using motivational approaches with families/LDMs.
* We are already looking at outcomes related to SDoH.
* Good relationships with DRW and BOALTC Ombudsman Programs (if needed in the development of this project).
* When a member’s cognitive level is high, participation is easier.
* When a member’s communication level is high, participation is easier.
* Community Care’s care management assessment already includes questions about community integration.
* Community Care has a strong training/learning & development department that includes e-learning options.
* Community Care care management values such as Member-Centered Care, Quality of Life, Community-Centered Care, Teamwork & Collaboration and Integrity are congruent with Community Connections.
* IDTS develop good relationships with members to not only identify their immediate service needs but to also assess overall quality of life, personal interests, etc.
* Community Care has a strong QI focus to not only implement plans/goals but also to evaluate effectiveness and sustainability.
 | * Technology barriers for members to know what is available to them.
* Transportation – lack of, expensive and/or not available as much on evenings and weekends
* Members who need physical assistance to get around, toileting/hygiene, etc.
* Residential providers not providing CC opportunities even though it is in contract.
* All the competing DHS projects that require intense resources: AQRs, implementation of AIRS, EVV, etc.
* When a member’s cognitive level is low, it would be more difficult to participate in community-based activities.
* When a member’s communication level is low, it would be more difficult to participate in community-based activities.
 |
| **Opportunities** | **Threats** |
| * Utilize incentive funding from P4P to help with transportation costs.
* Community education to create more opportunities for member involvement
* Some communities have focused on DEI including disabilities.
* MCOs could work with ADRCs and ILCs to discover opportunities about what they offer and engage our members.
* Educating legal decision-makers on the benefit of Community Connections to get their buy-in for members.
* A solid training curriculum will help reduce IDTS assumptions and/or biases about whether certain members can or want to participate in community life.
* Working with complex members to find ways for them to be involved in community life as they wish.
* Technology can be an opportunity for members to connect virtually with people or places (e.g., church, online groups, etc.) that help them stay engaged. This may be a great option in the winter months.
 | * Guardians and other family members may be barriers due to perceived risks.
* Rural areas have fewer opportunities for members to participate.
* Continued push to use technology to find activities, register for them, pay for them, etc.
* Members with restrictive measures/court restrictions have limits to participation and/or may post a threat to themselves or others.
* Communities not open to have members with physical and/or MH needs be more active or independent.
* Possible funding and other resource challenges depending on the types of activities.
* Not enough staffing to support member involvement in the community
* Transportation – lack of, expensive and/or not available as much on evenings and weekends
* No other state has taken on a community connections initiative state-wide across multiple target groups via a funding source requirement.
* Community facilities have varying degrees of accessibility.
* WI is a county-based culture – difficult to have a state-wide effort when there is so much variation from county-to-county.
* COVID can still pose a threat to member’s health and guardians/family members may not want members participating in community life for fear of contracting COVID.
* The weather in WI, both hot summer months and cold winter months, will likely affect the frequency of participation in community life.
* Each new contract requirement requires diverting resources from another project or initiative, especially when nothing has been taken away to free up the internal resources to refocus. This creates competing priorities for staff.
 |

# Part 2D: Strategic Plan for Community Connections and Changes in Practice

## 3. Using the summaries in Section 2C, provide measurable objectives to meet the Community Connection goals

## 4. Using the summaries in Section Part 2C, describe the strategies that MCOs will implement to meet the stated goals and objectives.

|  |
| --- |
| **Strategic Plan Goal 1****Incorporate standard Community Connections identification and support into the Family Care and Family Care Partnership member assessment and planning process.** |
| **Objective A:** Community Care will engage in Community Connections capacity building by facilitating training, education and feedback opportunities for members, community leaders and other stakeholders.Strategy 1 * Create a Community Connections information overview in both print and in-person/virtual presentation format that addresses the vision and goals of the Initiative and is flexible enough for all audiences.

Strategy 2* Identify the member and community opportunities to provide ongoing training, education and information to the appropriate groups.

Strategy 3: * Identify a group of Community Care staff that will take the lead on engaging with members and the community, utilizing the materials created.
	+ Strategy 3a: Create an annual schedule of at least six educational/informational opportunities each year.

Strategy 4: * Document any presentations or print materials that were conducted or provided annually, in what format and to which audience.

Strategy 5: * Document any significant feedback from these sessions to add to the SWOT analysis.
	+ Strategy 5a: Review the additional SWOT items at least annually to assess Community Connections strengths and barriers that could inform any changes that may be needed to strengthen the practice.
 |
|  | ***KPI A:*** *The number of community learning opportunities provided annually.* | ***KPI***  | ***KPI***  |
| **Numerator** | The number of learning opportunities provided annually. | n/a | n/a |
| **Denominator** | The number of learning opportunities planned annually. | n/a | n/a |
| **Inclusion/****Exclusion Criteria** | No exclusions beyond cohort criteria. | n/a | n/a |
| **Sampling Technique and Confidence Interval** | None. | n/a | n/a |
| **Internal MCO Data Collection Frequency** | Once annually. | n/a | n/a |
| **Method for Data Collection** | MCO data compilation via training dates and attendance records. | n/a | n/a |
| **Data Stratification** | Stratification by GSR. | n/a | n/a |

Part 2D.4.b – The success of the strategies for Objective A will be the completion of six educational/training opportunities per year. In addition, any changes to SWOT items, especially related to taking advantage of opportunities or addressing weaknesses and threats that break down barriers for members will also be considered success.

|  |
| --- |
| **Strategic Plan Goal 2** **Identify opportunities for member-specific, meaningful Community Connections for Family Care and Family Care Partnership members.** |
| **Objective B:** Community Care will customize data systems to document and assess Community Connections member interventions, goal attainment, barriers and use of natural supports.Strategy 1: * Determine what tools and system changes will need to be made to fully assess member interest, progress, barriers and use of natural supports toward Community Connection goals.

Strategy 2: * Train IDT staff on how to utilize the new tools and enter member data.

Strategy 3: * Conduct data reports at least twice per year to catch any missing information and follow-up with assigned IDT staff.

Strategy 4: * Run data reports, to include member demographics, annually to monitor member interest, progress toward goal attainment, individual or community barriers noted and the use of natural supports.
	+ Strategy 4a: Analyze the data to inform and implement any changes that could enhance Community Connections practice.
 |
|  | ***KPI B:*** *Percent of identified cohort members per the Interest Inventory who have Community Connections goals in their care plans.* | ***KPI*** | ***KPI*** |
| **Numerator** | Count of cohort members who have expressed an interest to or increase involvement in community life and have Community Connection goals in their care plan. | n/a | n/a |
| **Denominator** | Count of cohort members that have expressed an interest to increase involvement in community life. | n/a | n/a |
| **Inclusion/****Exclusion Criteria** | No exclusions beyond cohort criteria. | n/a | n/a |
| **Sampling Technique and Confidence Interval** | None. | n/a | n/a |
| **Internal MCO Data Collection Frequency** | Quarterly. | n/a | n/a |
| **Method for Data Collection** | MCO data compilation via member information collection system. | n/a | n/a |
| **Data Stratification** | Stratification by member interest level from the most recent Interest Inventory. | n/a | n/a |

Part 2D.4.b – The success of the strategies for Objective B will be determined by whether a care plan goal exists for members who have expressed a desire to be more involved in their community.

|  |
| --- |
| **Strategic Plan Goal 3** **Increase or maintain the percent of Family Care and Family Care Partnership members self-identifying as being active and having meaningful Community Connections.** |
| **Objective C:** Community Care will IDT staff will actively problem-solve through member barriers related to participation in community connections.Strategy 1: * Utilizing member answers from the Interest Inventory, any responses indicated in Section F of the Inventory will require more exploration with the member to address those barriers.

Strategy 2: * Develop and train IDT staff on the use of supplemental tools that will enable IDT to address the identified barriers.

Strategy 3: * Train IDT staff on how to develop care plan goals related to addressing barriers.

Strategy 4: * Conduct data reports at least twice per year to catch any missing information and follow-up with assigned IDT staff.

Strategy 5: * Run data reports twice annually to monitor member barriers indicated in Section F of the Interest Inventory.
* Strategy 5a: Analyze the data to inform and implement any changes that could enhance Community Connections practice.
 |
|  | ***KPI C:*** *Percent of cohort members that have reported a barrier in Section F of the Interest Inventory during the initial assessment.* | ***KPI***  | ***KPI*** |
| **Numerator** | Count of cohort members who have barriers identified in Section F of the Interest Inventory at the time of reassessment. | n/a | n/a |
| **Denominator** | Count of cohort members who have barriers identified in Section F of the initial Interest Inventory. | n/a | n/a |
| **Inclusion/****Exclusion Criteria** | No exclusions beyond cohort criteria. | n/a | n/a |
| **Sampling Technique and Confidence Interval** | None. | n/a | n/a |
| **Internal MCO Data Collection Frequency** | Twice annually. | n/a | n/a |
| **Method for Data Collection** | MCO data compilation via member information collection system. | n/a | n/a |
| **Data Stratification** | Stratification by member barrier identified in Section F of the most recent Interest Inventory. | n/a | n/a |

Part 2D.4.b – The success of the strategies for Objective C will be determined by an overall reduction of members reporting barriers in Section F of the Interest Inventory upon reassessment.

Below is a chart that illustrates how Community Care’s objectives, KPIs and strategies are connected to the MCO shared vision and strategic goals.



For Incentive 1, Requirement 1, Community Care will utilize MCO Collective Objective 2, Strategies 1 and 2, and Individual Objective B, Strategies 1 and 2, to demonstrate the tools, training and data reporting systems that were developed to carryout the approved Strategic Plan starting Q1 of 2024. For Incentive 1, Requirement 3, Community Care will utilize MCO Collective Objective 2. For Incentive 1, Requirements 2 and 4, Community Care will utilize Community Care Objective C. Refer to Section 5.d. below for additional information.

## For each objective, summarize the implementation tools and/or systems that will be utilized to implement the objective and strategies, and measure the outcomes. Summarize how health equity considerations are incorporated into the tool or system used.

1. If the tool or system is already utilized by the MCO or if it will be a new development or modification of the existing system;

For each of the objectives identified, Community Care will utilize the PDSA cycle to learn more about what is working and what may need adjusting based on the data, feedback from members, stakeholders and IDT staff. Community Care will be adding the Community Connections data collection requirements for IDT staff to their care management dashboards. This will prompt staff to ensure that the Interest Inventories, care plan goals and other data is completed at the determined intervals. The process of evaluating information is outlined in the strategies and Community Care will assign the applicable internal departments to take the lead on data and/or feedback collection and analysis. Information learned from this reporting will be shared with the Community Care P4P Steering Committee and applicable subcommittees to determine any next steps. Part of the data collection and analysis will involve identifying any barriers to community involvement that may be related to health equity. Examples of data to be analyzed may include: living environment (urban vs. rural) and if a member reports anything that makes them uncomfortable participating in their community due to gender, race or disability. It is anticipated that at least quarterly, reports will be created and analyzed for all required P4P outcomes, whether required or for internal quality improvement purposes. If any changes or modifications to practice are indicated to better serve members, these changes will be made, communicated and/or trained to IDT staff, tools and systems will be adjusted and the above strategies and KPIs may also need revising to be in line with the changes.

MCO Collaborative Objective 1:

Community Care will utilize the existing learning and development program to administer both the pre and post-training assessment. This will allow efficiency in both gathering and analyzing of the scores over time.

MCO Collaborative Objective 2:

Community Care will be making modifications to the member assessment tool and care plan that will allow IDT staff to better capture member demographics, interest in community connections, care plan goals, and barriers to success. Modifications to the member information database will also need to be made to capture this information for reporting and analysis.

MCO Collaborative Objective 3:

Community Care will utilize the community readiness survey and data collection tool developed by all MCOs.

Community Care Objective A:

* Per the strategies identified above for this objective, new communication tools will be developed both in print form for distribution, electronically via the Community Care website and other social media platforms and in a format for in-person meetings.
* A tracking system will be developed to record the community sessions held and number of print materials that were distributed and to what group.

Community Care Objective B:

Community Care will enhance care management tools and member data collection system to be able to record specific community connections goals, progress, barriers to progress and the use of natural supports.

Community Care Objective C:

Community Care will utilize the Interest Inventory, specifically Section F, to identify any barriers the member is reporting that hinders them from participating in meaningful community connections. In addition, Community Care has created additional tools, “Supplementary Member Exploration Questions for Community Connections” and “Community Asset Mapping Tool” to assist IDTS to problem-solve through barriers and develop care plan goals to reduce barriers. See Appendices 1 and 2.

1. How the MCO plans to engage with their members;

MCO Collaborative Objective 1:

The Community Connections training curriculum includes tools and resources designed to help IDT staff engage members in conversations about their interests, passions and goals to be more involved in their community. These tools will allow IDT staff to engage with members about personal needs beyond health and safety.

MCO Collaborative Objective 2:

Utilizing the Interest Inventory, Community Care will engage members in a discussion about their current level of participation in their community and whether they have additional needs or desires. Where members express wanting to be more active in community life, the IDT staff will utilize person-centered planning to create achievable care plan goals for the member and evaluate the progress of these goals. In addition, IDT staff will continue to engage members on an ongoing basis to assess whether members have changed their desire to participate in community life and/or specific activities.

MCO Collaborative Objective 3:

Community Care will include members as part of the MCO Collaborative Community Readiness Activity, gathering their feedback and input into what they know is available in their community and where there may be gaps or barriers.

Community Care Objective A:

Community Care will continue to engage members through our quarterly Member Advisory Committee meetings and involve them in GSR stakeholder meetings. In addition, Community Care will develop an ongoing series in our Connections Newsletter highlighting topics like how to get involved in community, member stories of involvement and other community resources.

Community Care Objective B:

Members will be engaged in identifying community connections goals and what steps they need to get more involved if they have expressed a desire to do so.

Community Care Objective C:

As an ongoing practice, all cohort members with barriers identified in Section F of the Interest Inventory will have a goal on their care plan addressing ways to reduce the barrier(s). The goal will be member-centered and within the scope of what may be resolved by the member and/or IDT staff, providers, family members or other stakeholders.

1. Timeline(s) and detail description(s) of what the new development(s) or modification(s) will involve; and

MCO Collaborative Objective 1:

Following DHS approval of the Community Connections IDT staff training curriculum, Community Care will implement the following within 30 days:

* specific training slides, tools, and other resources,
* finalize training dates and times,
* create and send out training registration information, and
* administer the pre-training assessment tool

MCO Collaborative Objective 2:

Following DHS approval of the Interest Inventory, Community Care will need approximately 90 days to add the Inventory to the member assessment, add it to the member information system and test it to ensure it is fully functional prior to January 1, 2024.

MCO Collaborative Objective 3:

Following DHS approval, Community Care will need about nine months to develop and execute a coordinated plan with all MCOs to conduct the community readiness activities. This includes:

* identifying one county in each GSR for the survey,
* identifying leadership in each GSR to conduct the survey,
* identifying the stakeholders in each GSR that will agree to complete the survey,
* conducting the survey and collecting data, and
* compiling the survey data to share with other MCOs, identifying any themes or other significant information that addresses Community Connections readiness in each GSR.

Community Care Objective A:

* Creating print materials for distribution will take about six to nine months. Community Care anticipates having these ready by the start of Q2 2024. The planning for the Connections Newsletter series is already underway and will continue quarterly.
* Developing a schedule for community/stakeholder sessions will take about six months. Community Care anticipates these meetings could begin in Q2 of 2024. This will entail putting together a basic Community Connections overview and list of questions, identifying leaders to facilitate these sessions, training them on content and how to record feedback to bring back to Community Care leadership as part of our PDSA process.

Community Care Objective B:

* Community Care will need to revise the comprehensive assessment tool, care plan and make data entry changes in our system to ensure we are capturing all of the necessary data. Once the initial changes have been made, testing the system will take time to ensure we have everything linked together and can run reports on the data needed for the P4P. Community Care anticipates having this ready prior to the end of 2023 so that IDT staff can be trained on the new tools and data entry for data collection starting in January 2024.
* Community Care has also developed a “Supplementary Member Exploration Questions for Community Connections” tool to further assist members in identifying their interests, passions, gifts and level of desire to be more involved in their community when the Interest Inventory has not gathered enough information to create a Community Connection plan. See Appendix 1.

Community Care Objective C:

* Community Care will need to add the Interest Inventory to their member database to allow for reports to be generated from the responses. In addition, there will need to be a link created between Section F of the Interest Inventory and the care plan goals. Once the initial changes have been made, testing the system will take time to ensure we have everything linked together and can run reports on the data needed for the P4P. Community Care anticipates having this ready prior to the end of 2023 so that IDT staff can be trained on the new tools and data entry so that member satisfaction can be collected starting in January 2024.
* Community Care has created additional tools, “Supplementary Member Exploration Questions for Community Connections” and “Community Asset Mapping Tool” to assist IDTS in further exploring a member’s interests, passions and opportunities to get more involved in their community. These tools are intended to be a dynamic, changing as needed based on a member’s current interest level in different types of activities and to address any barriers identified in Section F of the Interest Inventory. See Appendices 1 and 2.
1. Identify which implementation tool or system change is for the 2024 Specific Incentive Plan. This can be a pilot of a tool or system change and does not have to be technology based.

MCO Collaborative Objective 1: Not applicable.

MCO Collaborative Objective 2: Not Applicable

MCO Collaborative Objective 3: Not applicable.

Community Care Objective A: Not applicable.

Community Care Objective B Not Applicable

Community Care Objective C: Member Interest Inventory for all cohort members. Supplementary Member Exploration Questions for Community Connections and/or the Community Mapping Tool as applicable based on the barriers identified in Section F of the Interest Inventory.

* 1. Document any related future system or technology-based improvements that will be implemented after **Quarter 1 of 2024**.

MCO Collaborative Objective 1: None identified at this time.

MCO Collaborative Objective 2: None identified at this time.

MCO Collaborative Objective 3: None identified at this time.

Community Care Objective A: None identified at this time.

Community Care Objective B: None identified at this time.

Community Care Objective C: None identified at this time.

## Summarize a sustainability plan for continued improvement toward meeting the vision of this initiative beyond the 5-year cycle, including but not limited to:

Community Care will continue to train IDT staff in the Community Connections training curriculum moving forward, which includes the full curriculum for new staff and annual refresher courses for ongoing staff. Included in this training is the technical aspect of how to complete assessments and care plans that will create a data set for understanding members’ involvement in and satisfaction with an active community life. At least annually, Community Care will be analyzing data related to Community Connections to identify practice strengths, member barriers and progress toward care plan goals. In addition, Community Care will continue to follow the research and national best practices related to Community Connections so that we can implement any practice changes that would assist our members in leading the community life they desire.

In addition to IDT staff, Community Care will continue to hold provider, stakeholder and member Community Connections training and information sessions within the assigned GSRs. Community Care will also continue to maintain and build partnerships with community leaders and other stakeholders that will help to advocate for and potentially develop community engagement opportunities for members.

how the MCO will continue to address and monitor the barriers, provider network capacity, and community readiness as described in the inventory of current practices in Part 2C;

Community Care will address and monitor barriers via the Interest Inventory, other assessment tools and care planning process with members. IDTS will document barriers with members as they arise and create a plan to address those that are within the scope of the care team. Regarding network capacity and community readiness, this will also be assessed through work with individual members, noting any barriers and successes. Community Care will also be conducting regular education and training sessions in GSRs to gather feedback and assess what is available to members to participate in, where there may be gaps and the barriers to access. All of the information will be collected as least annually for further discussion with IDTS, members, stakeholders, the community and DHS so that any gaps or barriers can be addressed.

c. how health equity will continue to be infused throughout the initiative, including;

i. how the stratified data obtained will be incorporated into the chosen model of change or logic model, and

Community Care will utilize Community Connections member data to determine practice strengths, weaknesses, opportunities and threats. Where weaknesses or opportunities exist, Community Care will utilize the Model for Improvement to identify, implement and measure any changes that intended to improve practice. Utilizing the PDSA cycle, any implemented changes would be tracked and data further analyzed to test whether these changes had the intended impact. This process will be repeated as needed.

 ii. how disparities will be identified and addressed;

Community Care will utilize member data, including demographic information, to help determine whether any health equities exist in a member’s ability to participate in desired community life. Barriers that are within the scope of practice will be further assessed with the member, providers or other stakeholders as needed to create strategies to address disparities. If the identified barriers are outside the scope of practice, Community Care will collect this information and bring forth to DHS for ongoing discussion as we work through the P4P cycle.

d. how the stakeholder groups will continue to be engaged and feedback assessed and incorporated into the initiative; and

Community Care will engage in Community Connections capacity building by facilitating training, education and feedback opportunities for members, community leaders and other stakeholders in assigned GSRs. This is one of Community Care’s objectives outlined in Part 2D.3 and 4, which contain KPIs and strategies. Please refer back to that section for more details.

1. how sustainability will be maintained beyond the 5-year initiative cycle.

Community Care is currently engaging members in discussions and activities of enhanced community integration and community life. The ability for members to live as independently as possible in the ways that they choose and desire is part of Community Care’s core practice values. These values are infused into staff training and are infused in the tools we use for assessment, care planning and goal setting. The implementation of Community Connections will only serve to deepen and strengthen the current practice. Community Care is committed to creating tools, systems and data that will become the standard for Community Connections beyond the 5-year initiative cycle. Community Care will continue to utilize our quality improvement practices to analyze data and outcomes that will help to inform any changes needed to strengthen the work with members. In addition, Community Care will continue to keep abreast of national benchmarks for Community Connections to remain on the cutting edge of this work that we know will not only benefit our members but strengthen communities as a whole. Working alongside community leaders, service providers and other stakeholders, Community Care will continue to be advocates for members so that they can lead the lives they so choose. Community Care is committed to maintaining a strong and active presence in communities to continue to educate and support members’ ability and desire to have a rich and meaningful community life.

# Part 2E: Training and Technical Assistance Plan

1.a. & b. Please refer to the slide deck that was attached to the submission email for IDT training curriculum.

## 4. For each IDT staff training outlined in item 1 also include

## a. Training method(s) include length of each training and if the training is synchronous or asynchronous;

Community Care anticipates that the full curriculum for the Community Connections training will be approximately four hours long and will occur in asynchronous sessions. Annual refresher training will be approximately 60 minutes long and will also occur in one session.

## b. Instructors/training leaders/facilitators qualifications; and

Instructors/facilitators will be Community Care leaders with expertise in our target groups, with our care management model, and those that have been involved in developing this initiative. Community Care has not identified all of our trainers but at a minimum, the core trainers will be:

Theresa Baker, Director of Quality

Jennifer Mathwig, Regional Program Director

Nancy Leipzig, Region Program Director

Denise Piz, Community Connections Project Consultant

## c. How the training will be documented.

Community Care will document all staff training in our Learning & Development electronic system.

Appendix 1

**Supplementary Member Exploration Questions for Community Connections**

**(**Adapted from: The Peer Facilitated Community Inclusion Toolkit;Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities)

This tool was developed as a supplementary assessment tool to the Community Connections Interest Inventory. The purpose of the tool is to help members identify their interests, passions, gifts and level of desire to be more involved in their community when the Interest Inventory has not gathered enough information to create a Community Connection plan.

The use of this tool is very flexible, meaning that not every section needs to be administered or every question answered. In the spirit of person-centered practice, ask only the necessary questions that help the member better learn about themselves, their gifts and interests if they choose to do so.

**Identifying and Affirming My Past Successes Exercise**

*1) What would* ***you*** *say are the most important things that you have accomplished in your life?*

*2) What accomplishment(s) are* ***you*** *most proud of in your life?*

*3) What are the positive attributes and skills that* ***you*** *have that helped you to achieve these things?*

*4) What are the supports that you have had that helped you to be successful?*

**Inventory, Freqency and Importance of Applicable Activities**

|  |  |  |
| --- | --- | --- |
| **Have you participated in this activity in the last 30 days either by yourself or with friends or family?** | **Do you have an interest in participating in this kind of activity?** | **Is this activity important to you?** |
|  | Not Interested | Somewhat Interested | Definitely Interested | Yes | No |
| Shopping at a retail shop, garage sale, mall, etc. |  |  |  |  |  |
| Go to a restaurant or coffee shop. |  |  |  |  |  |
| Attend religious services or a religious activity. |  |  |  |  |  |
| Go to a movie. |  |  |  |  |  |
| Go to a park or recreation/community center. |  |  |  |  |  |
| Attend a sporting event. |  |  |  |  |  |
| Go to a zoo, museum, botanical garden, etc. |  |  |  |  |  |
| Go to the library. |  |  |  |  |  |
| Attend a cultural event. |  |  |  |  |  |
| Run errands – post office, grocery shopping, etc. |  |  |  |  |  |
| Go to a gym or exercise facility. |  |  |  |  |  |
| Go to a barber shop, beauty shop, spa, nail salon, etc. |  |  |  |  |  |
| Attend or participate in an advocacy/political event or meeting. |  |  |  |  |  |
| Participate in a 12-step program, therapy or other self-help program. |  |  |  |  |  |
| Participate in a social group – book club, arts & crafts, other hobby. |  |  |  |  |  |
| Participate in schooling or classes for credit or personal growth. |  |  |  |  |  |
| Host family or friends in your home. |  |  |  |  |  |
| Attend a community fair, event, block party, etc. |  |  |  |  |  |

Appendix 2

**Community Asset Mapping Tool**

**(Adapted from: The Community Building Tool Packet - Community Asset Mapping Workbook;**

**Community Legacy Program of Our United Villages, Portland, OR; 2012)**

**Purpose**:

Community Asset Mapping refers to the process of creating an inventory of the skills, talents and resources that exist within a community or neighborhood. Identification of assets and skills, possessed by residents, businesses, organizations and institutions, can support neighborhoods in reaching their optimum potential.

**Values and Goals of Asset Mapping:**

Get to the heart of community assets:

• Recognize that everyone has skills and talents that are relevant to community well-being.

• Embrace the belief that each time individuals exercise their abilities, the community in which they live is strengthened.

• Envision neighborhoods, communities, as places where capacities of individuals are identified, valued, and moved into action.

• Be respectful and mindful of cultural sensitivities in the approach.

• Strive for inclusivity.

**Understanding Community Assets**

A community asset or resource is anything that improves the quality of a community. Community assets can include:

• Expertise and skills of individuals in the community

• Citizen groups

• Natural and built environments

• Physical spaces in the community (schools, churches, libraries, recreation centers)

• Local businesses and services

• Local institutions and organizations (private, public, nonprofit)

**THE ASSET MAPPING PROCESS**

Identifying and mapping assets in a neighborhood or community can be as simple or as in-depth needed to create the best experience for members. While each asset mapping project will ultimately involve different steps and outcomes, there are several key elements to consider:

• Identify and involve partners

* Depending on the scope of the asset map, you may want to explore potential partners for involvement based on shared interest. Partners may include guardians, family members, friends and service providers. Engage enough to strengthen capacity for a successful outcome.

• Define a member’s community or neighborhood boundaries

* Determine the boundaries that community mapping will include based on where a member resides and the location of a variety of community activities. Is the asset map of a street, block, neighborhood or wider community? Is the map being creating based on specific interests or topics (i.e. transit options, parks, restaurants, dog parks)?
* It is likely that access to transportation will become a factor in the deciding on the boundaries.

• Determine what types of assets to include

* These should be based on what the member has already articulated about their interests, passions, and gift.
* Examples include: organizations, restaurants, religious groups, arts & theatre, volunteering opportunities and sporting events.
* Consider the three A’s:
	+ Availability of goods and services available in the community
	+ Affordability of options made available and whether this is something that would be paid for by the member or MCO
	+ Accessibility to utilize goods and services that are available (e.g., location, transportation, physical accommodations).

• Document assets

* Document any identified community assets in the care plan or in another place that the member and the team can readily access when needed. Add to this list as more information comes up.
* You can document the assets in a list or in a visual representation like the examples below, adding and changing information as needed in each section as time goes on.



**What’s in My Neighborhood Map?**

|  |  |
| --- | --- |
| What are the major streets for shopping, services, and entertainment? | What are the public places (library, community center) that people go? |
| What do people do for fun? Where do they go? | What clubs/organizations do people join? |
| What are the opportunities to get involved? | What is unique to your community? |
| Where is the center of the community? What is there? | Where do people gather? |

Adapted from, McKnight J. Take a Walk around Your Community – What do You See? - in Davies and Bolton, (1996). A Guide to Developing Community Connections, pp. 12-13. (http://www.allenshea.com/CIRCL/connections.pdf)