**Community Connections**

Pay For Performance 2023

iCare’s Individual Plan

Individual MCO Proposal Submission Part 2: C, D, and E

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.

# 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) RCAC

## 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.).

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

      i.    Non-Institutional Living:

* 1. Members in own home or apartment;
		+ 1. Q1 Total: 1128
			2. Per 100 Enrollees: 77.15

**Source:** SQL Server Management Studio --> FDA Database --> FCPServiceCodeMapping

* 1. Members receiving supported home care;
		+ 1. Q1 Total: 839
			2. Per 100 Enrollees: 57.39

**Source:** SQL Server Management Studio --> FDA Database --> FCPServiceCodeMapping

* 1. Members in residential settings (provide utilization data for each subcategory);
		1. 1-2 Bed AFH
			1. Q1 Total: 24
			2. Per 100 Enrollees: 1.64
		2. 3-4 Bed AFH
			1. Q1 Total: 120
			2. Per 100 Enrollees: 8.21
		3. CBRF with less than 8 people
			1. Q1 Total: 12
			2. Per 100 Enrollees: 0.82
		4. CBRF with more than 8 people
			1. Q1 Total: 42
			2. Per 100 Enrollees: 2.87
		5. RCAC
			1. Q1 Total: 20

Per 100 Enrollees: 1.37

**Source:** SQL Server Management Studio --> FDA Database --> TruCare Analytics database (Service request, offer, and line items)

      ii. Institutional Living:

* 1. Number of members in SNF (nursing home)
		+ 1. Q1 Total: 105
			2. Per 100 Enrollees: 7.18

**Source:**  SQL Server Management Studio --> FDA Database --> FCPServiceCodeMapping

* 1. Number of members in Centers (FDD/ ICF-IDD)
		+ 1. Q1 Total: 1
			2. Per 100 Enrollees: 0.07

**Source:** SQL Server Management Studio --> FDA Database --> FCPServiceCodeMapping

iii. Daytime Services:

* 1. Prevocational services community-based;
		+ 1. Q1 Total: 0
			2. Per 100 Enrollees: 0

**Source:** SQL Server Management Studio --> FDA Database --> FCPServiceCodeMapping

* 1. Prevocational services facility-based;
		+ 1. Q1 Total: 0
			2. Per 100 Enrollees: 0

**Source:** SQL Server Management Studio --> FDA Database --> FCPServiceCodeMapping

* 1. Daily living skills training – home and/or community;
		+ 1. Q1 Total: 4
			2. Per 100 Enrollees: 0.27

**Source:** SQL Server Management Studio --> FDA Database --> FCPServiceCodeMapping

* 1. Adult day care – facility based;
		+ 1. Q1 Total: 39
			2. Per 100 Enrollees: 2.67

**Source:** SQL Server Management Studio --> FDA Database --> FCPServiceCodeMapping

* 1. Consumer education and training;
		+ 1. Q1 Total: 0
			2. Per 100 Enrollees: 0

**Source:** SQL Server Management Studio --> FDA Database --> FCPServiceCodeMapping

* 1. Day habilitation services;
		+ 1. Q1 Total: 7
			2. Per 100 Enrollees: 0.48

**Source:** SQL Server Management Studio --> FDA Database --> FCPServiceCodeMapping

* 1. Counseling and therapeutic resources; and
		+ 1. Q1 Total: 56
			2. Per 100 Enrollees: 3.83

**Source:** SQL Server Management Studio --> FDA Database --> FCPServiceCodeMapping

* 1. Transportation – community specialized non-medical.
		+ 1. Q1 Total: 631
			2. Per 100 Enrollees: 43.16

**Source:** SQL Server Management Studio --> FDA Database --> FCPServiceCodeMapping

1. Report the total expenditure amount for CY 2022 for:
2. Non-Institutional Living (total for all settings listed in 4. a) i.).

 Total Expenditures for Q1 in Non-Institutional: $ 12,756,690.56

**Sources:** SQL Server Management Studio --> FDA Database --> FCPServiceCodeMapping

SQL Server Management Studio --> FDA Database --> TruCare Analytics database (Service request, offer, and line items)

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

Total Expenditures for Q1 in Institutional: $ 1,907,930.37

**Source:** SQL Server Management Studio --> FDA Database --> FCPServiceCodeMapping

1. iCare will incorporate the data components reflected above as baseline as well as future data, related to these same elements as the P4P continues. iCare will utilize the interest survey initially to gauge members’ current level of interest and level of satisfaction with current community connections. In addition, iCare’s current Social Comprehensive Assessment includes questions specific to community integration. The questions ask about the member’s level of satisfaction with community involvement as well as type of community activities that they are interested in. Initially, we may evaluate the previous responses related to these questions in the Social Comprehensive Assessment as part of our baseline data analysis. Ongoing monitoring will occur for specific community-based services offered in the benefit package, which includes day habilitation, pre-vocational and adult day services.
	1. We recognize that there are a number of components incorporated into some services offered in the benefit package related to, or with implied community integration. Examples of this include companionship incorporated in the SHC service codes, for members that require supervision or assistance to get out into the community. Another example is self-directed supports where the member develops a budget and plan that can incorporate community outings or accompaniment to social events or gatherings as part of members self-directing. Fiscal conduit, as part of the self-directed support services, is also an option where members may coordinate preferred transportation to and from community outings by using non-traditional transportation via SMV/van transport.
2. There are questions included in the current Social Comprehensive Assessment related to natural supports and satisfaction. Natural supports are addressed and incorporated in the assessment as well as the member centered planning process. During the member-centered planning process, it is determined whether the member’s needs are met independently, informally, or formally. We evaluate the effectiveness of natural supports during the member-centered planning process, however; we do not have a way to extract reference to natural supports from the MCP or to numerically calculate members with natural supports as they specifically relate to satisfaction with community connections within our current reporting structure.
3. We are currently evaluating our questions specific to natural supports already incorporated in the Social Comprehensive Assessment to determine if the way they are written will capture effectiveness specific to community connections. We are also considering capturing natural supports and their effectiveness in our Interest Inventory Assessment. This would give us a baseline of our membership who utilizes natural supports at the time of assessment.

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

When a member enrolls in the iCare Family Care Partnership Program, a Social Comprehensive Assessment is completed within 30 days of enrollment, and semi-annually. This assessment includes a group of specific questions which address community integration, education and employment, religion and spirituality, social supports, housing, social history, and any other connections or activities that may be important to the member.

All information gathered from the Social Comprehensive Assessment and through IDT staff dialogue with members and others they wish to include during the assessment process allows IDT staff to gauge the member’s current satisfaction with their life overall, including their interest in and level of community connections. This information allows IDTs to pinpoint areas in which satisfaction and opportunity for more community participation could be improved. In the social support sub-assessment, the member is asked if the amount of social connection is adequate, and if the member feels supported in the community. The IDT explores this with the member to assess if the member is interested in new/more community involvement or if additional support is needed to facilitate current community connections. The IDT may (with a signed Release of Information) communicate with social connections to explore how those social connections may be strengthened, while determining the amount of natural support the member has within their network, defining individuals closest to them (family, friends, neighbors, etc.), and understanding where they fit within their current social network. The goal is to make sure that the member’s natural supports and social connections remain involved in the member’s life to the extent the member desires and to wrap additional services/supports around those supports so the member has opportunities to strengthen current community connections or develop new ones.

The Social Comprehensive Assessment is focused on outcomes related to the member’s integration into the community. Those outcomes are then carried over into the member centered plan and the teams work with the member to determine what support is needed for those outcomes and what the member’s preferences are for that support. iCare has addressed community connections as part of the social comprehensive assessment and member centered planning process but has not specifically tracked level of community engagement as a measure. Because we have several questions related to community connections in our assessments, we believe that overall members who express interest in establishing or increasing community connections have obtained or increased their community connections. iCare has the ability to collect, stratify, and analyze data from the assessments we are currently using. iCare’s current assessment questions around community connections, valued social roles, religion/spirituality, transportation, and community integration are listed below:

* Is the member satisfied with the quality of the personal relationships they have in their life?
* Do we have a current signed releases of information (ROI) in document summary to talk with people in the member’s life?
* What is the member's marital status?
* Does the member have significant family members and/or friends in their lives?
* Does the member feel they have enough contact with them?
* Does the member want to include them in the IDT?
* Are there any concerns or risks identified with social supports at this time?
* How does the member access the community?
* Does the member use waiver-funded standard transportation?
* Are there formal supports in place for transportation?
* Is the member using self-directed supports to access transportation?
* Is the member satisfied with their transportation at this time?
* Are there informal/natural supports in place for transportation?
* How are informal/natural supports being coordinated with formal supports?
* Are there any risks present related to transportation?
* Are there any barriers/challenges to a successful transportation plan present?
* How does the member spend their day?
* Is there something the member wants to do regularly but isn’t doing?
* What does the member do for fun and/or entertainment?
* Is the member active in any community groups such as service clubs, ethnic groups, community centers etc.?
* Is the member interested in participating in any community groups?
* Does the member volunteer?
* Is the member interested in volunteering?
* Are there any formal supports in place to support the member’s desired level of community integration?
* Does the member have any informal/natural supports in place to support the member's desired level of community integration?
* Does the member’s current level of community integration meet their needs and preferences?
* How far did the member go in school?
* Is the member satisfied with their level of education?
* What is the member’s work history?
* Is the member currently working?
* Is the member interested in working in the next six months?
* Does the member identify any outcome or preference for education or employment?
* Is the member a part of a religious or spiritual organization?
* How important is their faith/spirituality in their life?
* Does the member participate as often as they would like?
* Does the member receive any formal supports to continue to practice their faith and/or spirituality?
* Are these supports meeting the member’s needs and preferences?
* Does the member receive any informal or community supports to continue to practice their faith and/or spirituality?
* Are these supports verified and meeting the member’s needs and preferences?

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

​**Members:** Members can experience personal or societal barriers to community integration. Members may be reluctant to or may not understand that they can talk with their IDT about their interest in community connections. We have several questions in our Comprehensive Social Assessment that ask about community connections in different ways to try to encourage the member to think about their connections to their community. For some members, community connections may not be their top priority at the time as they may be more focused on other needs. Some members may not understand how increasing community connectedness may benefit them. It may take time for the IDTs to have a meaningful conversation with a member about community connections. Mobility status, care needs, health conditions and other personal barriers may hinder integration into the community for some members. The need for transportation (especially wheelchair transport) for community integration can also be a barrier for members.

One of the main barriers to some community connections has been the public health emergency. Covid-19 has played a major factor in members’ ability and willingness to integrate into the community. Many social and community activities were cancelled during the pandemic. Some members/decision makers have been reluctant to participate in social/community activities because of fear of the spread of COVID. With the end of the public health emergency, it is expected that more members will have increased opportunities and an increased comfort level with community integration.

**The Community:** In many rural communities, especially, finding accessible events/activities can be a significant barrier. Community resources may not have knowledge or experience serving individuals with disabilities and/or medical complexities. Additionally, some community events/activities are not accessible to members who use wheelchairs. The general workforce shortage may also be a limiting factor as many employers are having difficulty recruiting and retaining staff for basic day-to-day business needs. Businesses may not have bandwidth to focus on building their capacity to become more inclusive.

**Service Providers:** A major barrier for providers in general is the lack of adequate staffing and resources to support the community integration initiative. As noted above, the general workforce shortage may be a limiting factor as many employers are having difficulty recruiting and retaining staff for basic day-to-day business needs. Service providers they may not have bandwidth to focus on building their capacity to provider a wider array or more individual services. Additionally, there are no billing codes for ‘community connections’ which may be necessary if there is a cost associated depending on the members’ interests or chosen activities.

**MCOs:** As noted above, system updates will be needed to change or add assessments that focus more specifically on community connections. IT resources will be needed to design and build reports to track data. Systems changes take at a minimum of 6 months and often longer, depending on competing priorities, to be planned, developed, and implemented. Additionally, risk mitigation to maintain health and safety for members is a large component of the Family Care Partnership program. The way risk is identified and mitigated, especially with the community connection initiative, will need to be reviewed and potentially adjusted. Additionally, training for IDT staff related to this initiative will need to be clearly defined and developed.

**Family Care Partnership Contract:** The P4P language in the contract should be flexible to allow for MCOs to customize their processes and approach to community connections. The focus of the Family Care Partnership Program is to support members to live as independently as possible, live full and meaningful lives and to improve the quality of healthcare services provided while remaining cost-effective. The paradigm shift to even greater community connection being a priority will increase costs and additional funding therefore a capitation rate increase will be needed.

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

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| --- | --- |
| **iCare** |  |
| **Strength**s1. Member Centered Planning process focuses on personal experience outcomes including community integration activities.
2. Social Comprehensive Assessment focuses on community integration and member goals.
3. IDT staff understands resources available for successful implementation.
4. iCare has reports available to pull member information/demographics.
5. Strong Learning and Development team to support the initiative.
6. Members schedule and track their own rides (both non-medical/medical).
7. Staff is local to communities they serve.
8. We have community resource staff who help identify gaps in community integration.
 | **Weaknesses**1. System updates will need to take place to support the initiative. A supplemental assessment will need to be developed with greater emphasis on community connections.
2. Metrics need to be established and system capability to track and produce reports will need to be developed.
3. IDT staff will need training and support to understand this greater focus on community connections and how to engage members/guardians in conversations about the importance of community connections and the member’s potential for exploring additional community connections.
4. Additional staff resources with skill in community development may be needed to help with development of community resources, increasing community awareness, etc.
 |
| **Opportunities**1. With the end of the public health emergency approaching, the desire to become involved in the community may be important to our membership base and there may be more opportunities as businesses continue to try to resume pre-pandemic operational levels.
2. Stakeholder outreach and training will bring more attention to this initiative and promote buy-in.
 | **Threats**1. Contracting Covid-19 has been a significant concern to members and has limited availability of activities in communities.
2. Caregiver and general workforce shortage has impacted some immediate service implementation, resulting in delays and limitation in provider choice in some instances.
3. Availability of transportation is an ongoing challenge and is greater when wheelchair transportation or out of county/region transport is needed for non-medical appointments.
4. For some members, perhaps especially those with behavioral challenges, increasing connections to community may increase risks for incidents. In these cases, careful planning will be needed to ensure success with community engagement. Pressure to move too quickly may result in a negative outcome.
5. We may need to find ways to contract with entities that are non-traditional providers to facilitate community connections.
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# 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.

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| --- |
| **Strategic Plan Goal 1 (Collective)– Incorporate standard Community Connections identification and support into the Family Care and Family Care Partnership member assessment and planning process.** |
| **Objective 1:** iCare’s IDT staff are prepared to conduct assessments and implement community connections.Strategy:* iCare’s Learning and Development team will conduct training on community connections within 90 days of start date using the internal training platform.

Evaluation of Success: * Evaluation of success: 95% of new staff has completed the community connections training within 90 days of start date.
 |
|  | ***KPI 1:*** New staff hired after initial Community Connections Training Session will receive training during the onboarding process, within 90 days of start date starting in Q1 2024. |
| **Numerator** | Count of new IDT who completed the Community Connections Training within 90 days of start date.  |
| **Denominator** | Count of all new IDT starting after initial training session. |
| **Inclusion/****Exclusion Criteria** | Excluding support staff in a non-IDT role. Excluding staff who happen to be on extended leave during time of training or that terminate employment within 90 days of start date. |
| **Sampling Technique and Confidence Interval** | Not applicable |
| **Internal MCO Data Collection Frequency** | Annual evaluation   |
| **Method for Data Collection** | Training completion will be tracked via our training platform.   |
| **Data Stratification** | Data will be stratified to capture exclusions  |
| **Measure Year(s):** | Ongoing |

|  |
| --- |
| **Strategic Plan Goal 2 (Collective)– Identify opportunities for member-specific, meaningful Community Connections for Family Care and Family Care Partnership members.** |
| **Objective 2:** iCare assesses member’s community activities and identifies members who are currently connected to their community and are satisfied with those community connections at initiation. Strategy:* iCare identifies members in the cohort who indicate during the initial interest inventory assessment that they are connected to their community and are satisfied with community activities.

Evaluation of Success: * When the member identifies barriers, this is documented in case notes and ways to explore community connections within the benefit package are explored.
 |
|  | ***KPI 1:*** Percentage of members currently connected to their community and report satisfaction with community activities on the Member Interest Inventory survey  |
| **Numerator** | Count of members in the cohort who are currently connected to the community and report satisfaction with community activities during the initial interest inventory assessment. |
| **Denominator** | Total count of members in the cohort as defined per calendar year.  |
| **Inclusion/****Exclusion Criteria** | Excludes members who are not part of the cohort at the given time (see exclusions in cohorts from strategic plan part 1). Excludes members who report no response or member declined on the Member Interest Inventory |
| **Sampling Technique and Confidence Interval** | Not applicable  |
| **Internal MCO Data Collection Frequency** | Annually |
| **Method for Data Collection** | Internal reporting mechanism run from member interest inventory assessments.  |
| **Data Stratification** | It will be stratified through internal reporting mechanisms and will be reported on annually. |
| **Measure Year(s):** | Ongoing |

|  |
| --- |
| **Strategic Plan Goal 3 (Collective) – Increase or maintain the percent of Family Care and Family Care Partnership members self-identifying as being active and having meaningful Community Connections.** |
| **Objective 3:** iCare maintains or increases the percentage of members currently connected to their community and report satisfaction with community activities (volunteering, employment, religious activities, etc.) as measured by initial and subsequent interest surveys conducted. Strategy:* iCare identifies members in the cohort who indicate during the subsequent interest survey that they are connected in their community and are satisfied with community activities.
* Strategy specific to 2024: IDT Staff will administer the interest inventory assessment (that they were previously trained on in Q4 of 2023) to members during each semi-annual assessment conducted every 6-months to determine a baseline and ongoing monitoring of satisfaction for members in the defined cohort.

Evaluation of success: * iCare will maintain or increase the percentage of members currently connected and who report satisfaction with community activities.
 |
|  | ***KPI 1:*** Increase or maintain the percentage of members who are currently connected to their community and report satisfaction with their community activities.  |
| **Numerator** | Count of members in the cohort who have had an initial interest inventory assessment conducted and are involved in their community and are satisfied with their community activities as reported at the time of subsequent assessment.  |
| **Denominator** | Total count of members in the cohort, not meeting exclusion criteria, as defined per calendar year.  |
| **Inclusion/****Exclusion Criteria** | Excluding members who do not want to be involved in community connections. Excluding members who are not part of the cohort. Including members who are part of the cohort. Excludes members who report no response or declined on the Member Interest Inventory survey. |
| **Sampling Technique and Confidence Interval** | Not applicable |
| **Internal MCO Data Collection Frequency** | Annually |
| **Method for Data Collection** | Internal reporting mechanism run from the member interest inventory assessments |
| **Data Stratification** | It will be stratified through internal reporting mechanisms and reported out annually.  |
| **Measure Year(s):** | Ongoing |

**Summary of Goals and Objectives related to 2023 Incentive 1:**

Incentive 1 Requirement 1: This will be reflected in collective goal 3 and objective 3 above.

Incentive 1 Requirement 2: This will be reflected in collective goal 2 and objective 2 above.

Incentive 1 Requirement 3: This will be reflected in collective goal 2 and objective 2 above.

Incentive 1 Requirement 4: This will be reflected in collective goal 2 and objective 2 above.

## 5.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;
2. How the MCO plans to engage with their members;
3. Timeline(s) and detail description(s) of what the new development(s) or modification(s) will involve; and
4. 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.
	* 1. Document any related future system or technology-based improvements that will be implemented after **Quarter 1 of 2024**.

**Internal Objective 1: iCare’s IDT staff are prepared to conduct assessments and implement community connections.**

1. iCare has an established online training platform where we will incorporate the new Community Connection training. This can track all training completed by new and existing hires. Pre/post-tests also measure competency. A health equity component will be incorporated in the Community Connection training.
2. iCare prioritizes community connections for our members. Incorporating the Community Connections P4P will offer further training for IDT staff on engagement during contacts with members. Discussions around community connections can take place during monthly phone contacts and/or during face-to-face visits with the members in their home environment.
3. New trainings will be developed as part of the Community Connections P4P. Community Connections trainings will be part of the onboarding process for new IDT hires beginning in 2024, and annually for current staff.
4. For this objective, there will not be a system change, but rather an addition to the new hire onboarding process to include more of an emphasis on community connections. In addition, training will be implemented and required for current staff at least annually.
5. Future system or technology-based improvements necessary after Q1 of 2024 will be evaluated.

**Internal Objective 2: iCare assesses member’s community activities and identifies members who are currently connected to their community and are satisfied with those community connections at initiation**.

1. First, iCare will use existing reporting and systems to run the proposed cohort of members that will qualify for the first phase of the Community Connections assessment process. We have existing reporting on member demographics, target group, classification, and current living situation that will be used to identify members of the cohort.
2. The current social comprehensive assessment captures information on the member’s social network and identifies satisfaction with community integration/connections. The “Member Interest Inventory Survey” will be added as part of the comprehensive assessment process to gain an understanding of members’ interest/satisfaction in community connections. Evaluation of interest and satisfaction through a health equity lens will be completed after initial interest inventory survey and the re-assessment period.
3. The social comprehensive assessment is completed upon enrollment into the Family Care Partnership program, and semi-annually thereafter. During the assessment process, the member is asked a series of questions around community connections, and the care plan is developed to be member centered.
4. The social comprehensive assessment is a tool that is currently utilized by the MCO. While there are applicable questions already in place surrounding community connections, iCare will include the Member Interest Inventory Survey as part of the current comprehensive assessment process. The process of integrating the Member Interest Inventory Survey into current systems is in development. The survey will be ready for implementation by January 2024.
5. We are exploring the options internally related to adding the Member Interest Inventory Survey to our (EHR) electronic health record or creating a survey to be administered the same way but will live outside of the EHR. System enhancements and/or changes will need to be in place by January 2024.

**Internal Objective 3: iCare maintains or increases the percentage of members currently connected to their community and report satisfaction with community activities (volunteering, employment, religious activities, etc.) as measured by initial and subsequent interest surveys conducted.**

1. The social assessment captures the members’ current involvement in the community and gauges interest in volunteer work, employment, religious activities/faith-based groups.
2. The social comprehensive assessment is completed upon enrollment and semi-annually. The “Member Interest Inventory Survey” will be added as part of the comprehensive assessment process to gain an understanding of members’ interest/satisfaction in community connections. Based on trends identified following data evaluation regarding health equity, intervention will be proposed.
3. The social comprehensive assessment is a tool that is currently utilized by the MCO but the Member Interest Inventory Survey will be added to capture that members are currently connected and satisfaction with community connection.
4. The response in Internal Objective 2 d. is applicable to this objective as well but in addition, if members express a desire to increase their community connections, but require support to do so, we will assist them by exploring options in the benefit package, current community offerings, as well as natural supports to increase their satisfaction. iCare will explore ways to increase opportunities for members (if desired), by working with Network Development for any potential ways to expand the network for the purpose of community connections.
5. Future system or technology-based improvements necessary after Q1 of 2024 will be evaluated.

## Summarize a sustainability plan for continued improvement toward meeting the vision of this initiative beyond the 5-year cycle.

1. iCare’s quality department has a Quality Improvement Work Plan. A one-time report will be conducted to ensure current staff have received adequate training for community connections. Ongoing sample audits will be conducted semi-annually to ensure assessments have been administered to gain an understanding of members’ current community connection satisfaction, as well as interest in improving community connections. Audits will focus on timeliness, follow-up to requests and potential barriers, and that an outcome related community connections was entered into the Member Centered Plan.
2. The barriers at the MCO level will be identified in the Quality Improvement Work Plan. Member level barriers will be audited (as mentioned in 2D: 6A). A sample will be pulled for these audits to ensure performance among IDT staff, and to identify additional opportunities for training/coaching if applicable. Training/coaching will be tracked with meeting minutes and/or attendance (if in person). iCare leadership and Network Development will continue to attend Network Adequacy meetings to discuss network capacity, opportunities, and barriers related to access of services and supports through contracted providers in relation to community connections.
3. The chosen model of change is the “Plan, Do, Study, Act” model. The measure of community connection satisfaction will be broken down into the following demographic categories: gender, age, race, and target group.
4. Disparities will be identified through reporting of the above population including direct member and/or guardian feedback, as well as other stakeholder input, identifying barriers to community connections, and partnering with the population health team to identify possible interventions. With stakeholder input, iCare will determine what improvements could be made in care management practice (e.g., network expansion, edits to assessments, further training, etc.).
5. Quality Improvement Committee meetings will be held quarterly with the opportunity to obtain stakeholder feedback. The Member Advisory Committee will continue to meet to obtain member feedback specific to this initiative. Current practices related to the community connections P4P will continue to be monitored and evaluated based on stakeholder feedback.
6. Staff will be adequately trained upon onboarding with iCare and annually. Audits will be completed semi-annually to ensure members in the defined cohort are assessed appropriately for their level of interest in community connections and possible goals related to becoming more involved within the community. Regular monitoring of data related to the measurement of increasing community connections will be incorporated into iCare’s practice of monitoring, similar to oversight related to other metrics and initiatives.

# Part 2E: Training and Technical Assistance Plan

## 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;

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

## c. How the training will be documented.

**Training Methods**: The initial training for the Community Connections P4P will be synchronous and will be completed in 4-6 hours. Ongoing training may be synchronous or asynchronous. Training methods will include instructor lead (virtual or in-person), online learning content, interactive scenarios, and small-group breakout sessions.

**Instructors/Leaders/Facilitators**: iCare’s internal facilitators include members of the Learning and Development Team: Penelope Gall (Manager, Care Management Resources), Margret Porter (Senior Learning Design Professional), and Christina Keoppen (Learning Facilitation Professional II). External facilitators to be determined.

**Training Documentation**: The Learning and Development Team utilizes a “New Employee Theory Checklist” to ensure the concepts of the position within the IDT are clearly understood. There is also an internal checklist that new staff signs off on to indicate that training has been completed. When in-person training is completed for this P4P, there will be a sign-in sheet, while attendance will be tracked for virtual trainings. Pre and post tests will document completion and comprehension in the online learning platform.