Community Connections

**Pay For Performance 2023**

**Proposal Submission Template**

**FACE SHEET**

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| MCO Name | Submission Date | | Proposal Prepared by | | |
| Lakeland Care, Inc. | 3/31/2023 | | Katie Calmes, Quality Director | | |
| Date of DHS Approval of Proposal: | | | | | |
| Proposal Title: Lakeland Care Community Connections Pay for Performance Strategic Plan | | | | | |
| Executive Sponsor: Jen Harrison, Chief Operations Officer Email: jen.harrrison@lakelandcareinc.com | | | | | |
| Project Manager(s) name and email address  1. Katie Calmes Email: [katie.calmes@lakelandcareinc.com](mailto:katie.calmes@lakelandcareinc.com) | | | | | |
| **MCO-Collective Team including steering committee and/or workgroup participants** | | | | | |
| Name | | Title/Role | | | MCO/Organization Name |
| Jen Harrison | | Chief Operations Officer / Executive Sponsor, MCO Joint Committee Representative, SWOT workgroup | | | Lakeland Care, Inc. |
| Katie Calmes | | Quality Director / Project Lead, MCO Joint Committee Representative, SWOT facilitator | | | Lakeland Care, Inc. |
| Jessica Quam | | Care Management Practice Support Director / Lakeland Care Community Connections Steering Committee, MCO Joint Committee Representative - Contract Language workgroup, SWOT workgroup | | | Lakeland Care, Inc. |
| Nathan Luedke | | Data Analytics & EMR Applications Director / Lakeland Care Community Connections Steering Committee, SWOT workgroup | | | Lakeland Care, Inc. |
| Angela Beaty | | Provider Relations & Contracting Director / Lakeland Care Community Connections Steering Committee, SWOT workgroup | | | Lakeland Care, Inc. |
| Stephanie Gruber | | Operations Support Coordinator / Lakeland Care Community Connections Steering Committee | | | Lakeland Care, Inc. |
| Stephanie Phillips | | Care Management Best Practices Manager / MCO Joint Committee Representative - Current Practice workgroup, MCO Joint Committee Representative - Training workgroup | | | Lakeland Care, Inc |
| Alisha Andrews | | Quality Risk Manager / Member Advisory-Engagement Committee Facilitator | | | Lakeland Care, Inc. |
| Kris Rusboldt | | Care Manager / Care Management Advisory Committee Member, MCO Joint Committee Representative - Member Engagement workgroup | | | Lakeland Care, Inc. |
| Brittany Grenke | | RN Care Manager / Care Management Advisory Committee Member, MCO Joint Committee Representative - Member Engagement workgroup, SWOT workgroup | | | Lakeland Care, Inc. |
| Laura Black | | Best Practice Lead / Care Management Advisory Committee Member, MCO Joint Committee Representative - Current Practice workgroup, MCO Joint Committee Representative - Member Engagement Subgroup | | | Lakeland Care, Inc. |
| Kristah M Warrington | | Aging and Long Term Care Director / Menominee Indian Tribe of WI, Tribal Advisory Committee Representative | | | Menominee Indian Tribe of WI |
| Carrie Lindsey | | Long Term Care Case Management Program Manager / Oneida Comprehensive Health Division, Tribal Advisory Committee Representative | | | Oneida Nation Tribe |
| Patty Albers | | Lakeland Care Member Advisory Committee Member | | | Lakeland Care, Inc. |
| Ginger Beuk | | Lakeland Care Member Advisory Committee Member | | | Lakeland Care, Inc. |
| Maggie McCullough | | Lakeland Care Member Advisory Committee Member | | | Lakeland Care, Inc. |
| Fritz Schmidt | | Lakeland Care Member Advisory Committee Member | | | Lakeland Care, Inc. |
| Steve Corbeille | | Lakeland Care Member Advisory Committee Member | | | Lakeland Care, Inc. |
| Carol Pautsch | | Data Analytics Manager, SWOT workgroup | | | Lakeland Care, Inc. |
| Katie Schultz | | Quality Manager, SWOT workgroup | | | Lakeland Care, Inc. |
| Veronica Deans | | HR Director, SWOT workgroup | | | Lakeland Care, Inc. |
| Jane Brackett | | Network Quality Manager, SWOT workgroup | | | Lakeland Care, Inc. |
| Kim Mickle | | EMR Applications Manager, SWOT workgroup | | | Lakeland Care, Inc. |
| Jason Berdyck | | Specialty Supports Manager, SWOT workgroup | | | Lakeland Care, Inc. |
| Tasha Mjos | | Best Practice Supervisor, SWOT workgroup | | | Lakeland Care, Inc. |
| Nate Johnson | | Provider Relations Supervisor, SWOT workgroup | | | Lakeland Care, Inc. |
| Taylor Tamayo | | Family Care Program Manager, SWOT workgroup | | | Lakeland Care, Inc. |
| Jamie Champine | | SDS Specialist, SWOT workgroup | | | Lakeland Care, Inc. |
| Miriah Kelley | | Best Practice Lead / RNCM, SWOT workgroup | | | Lakeland Care, Inc. |
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| Primary MCO Contact: Katie Calmes | | | | | |
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| Space for comments (as applicable) | | | | | |
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| **PART 1 Components A-B** | | | |
| **PART 1A**: **Strategic Plan Responsibilities and Objective** | | | |
| **Section Description:** This section outlines who in each MCO is responsible for the development of the collaborative Strategic Plan. It also details the collective MCO objective for adopting this initiative, the internal and external future state for the initiative, and the intended impact this initiative will have on members given the DHS Framework for Community Connections. | | | |
| **Corresponding Contract Requirements:**  Contract Requirements  1) An explanation of the Strategic Plan’s objective, including why the MCO is adopting this initiative and how the initiative will impact the outcome of advancing community connections.  2) A list of the MCO’s steering committee for the initiative that identifies the executive sponsor, the project manager(s), committee, and workgroup participants. | | | |
| Collective | Individual | Either | **MCO-Strategic Plan Components** |
| X |  |  | 1. Identify reasons for adopting this initiative. |
| **Reasons for adopting the Community Connections Initiative**  As a collaborative of five Managed Care Organizations working across the State of Wisconsin, we are deeply inspired by the Department of Health Services’ Community Connections P4P initiative. Working together with Members of our Family Care and Family Care Partnership programs to increase the percentage of those who are active in community life while providing opportunities to be socially connected in accordance with their personal preferences is the critical next step in the strategic growth and values-based development of each of our organizations.  We are adopting this initiative because it is fundamentally connected to the mission, vision and values of our organizations and honors our commitment to build diverse and inclusive communities where all people are welcomed, can feel a strong sense of belonging and thrive as they share their unique contributions. This initiative comes at an opportune time as people across the nation are rebuilding their social connections and community relationships after more than two years of intentionally distancing themselves because of the global COVID 19 Pandemic. As a sector we are also well positioned for meaningful change and transformation in our support for people with disabilities, their families and social support networks. Since the inception of the Family Care program, we have effectively transitioned to an effective Managed Care model and have completed significant work to understand the distinction between personal outcomes and long-term system outcomes of our work. Each of the organizations involved in this collaborative have strong leadership and represent long-standing history and expertise providing support to people with disabilities and older adults in Wisconsin. We have the resources, skills, passion, and focus to develop a plan for this this transformation.  Many older adults and people with disabilities continue to be stigmatized and isolated based on the complex challenges they face. At the same time, health care systems as well as community based providers continue to face challenges related to workforce shortages, inflation, and turnover rates. Many Wisconsin-based community providers have decreased the amount or frequency of services; some have closed their doors.  The Community Connections P4P initiative assembles a community-based response to these challenges through the identification and mobilization of a full spectrum of natural care and support that exists within each of our communities. It employs a person-centered approach to building relationships and connections that can become the foundation for each member to feel a sense of improved quality of life as a contributing member of their community. With our experienced care teams and robust member centered planning process, we can expand the scope of our work to enhance the services and supports a member needs to have a socially valued role in the community now and into the future. | | | |
| X |  |  | 2. Identify the collective vision for the Community Connections P4P Initiative including how the initiative will impact the outcome of advancing member’s community connections and valued social roles. |
| **MCO Collective Vision**  Through Community Connections, MCOs will engage members, providers, and the community to utilize the tools and assets available to support members in leading decisions as to how, when, and where they actively and safely participate in the communities where they live, work, and engage with others.  Through the Community Connections P4P initiative, MCOs will develop and refine the practices, tools, and resources to increase the collective focus on recognition that every member has a significant contribution to make to his or her community. Conversations about connections with other people and places in the community along with the roles members can have will be a focal point to all care planning and service coordination.  Members will benefit from practical impacts including:   * A care plan that recognizes their unique gifts, interests, skills, and preferences * An increased understanding of the assets that exist in their communities - people, welcoming places, groups, associations, and other opportunities to contribute and connect * An opportunity to have valued social roles in their community and participate in activities that are meaningful to them * A sense of companionship and encouragement from friends and natural support networks * Increased safety and security through supportive community connections.     Loneliness is defined as the emotional experience of being alone or not fitting in. Isolation results from barriers to participation and inclusion (Tanskanen & Anttila, 2016). Research has linked social isolation and loneliness to higher risks for a variety of physical and mental conditions: high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, cognitive decline, Alzheimer's disease, and even death (Cacioppo, Grippo, London, Goossens, & Cacioppo, 2015). People with disabilities report feeling lonely and being isolated at a rate four times more than people without disabilities, and this prevalence is compounded by age, income, race, and barriers to transportation and appropriate housing (Luhmann & Hawkley, 2016). The same has been documented for older adults; studies indicate that maintaining strong social connections and keeping mentally active with aging may lower the risk of cognitive decline and dementia (Luhmann & Hawkley, 2016). Although it is hard to precisely measure social isolation and loneliness, there is strong evidence that many adults aged 50 and older are socially isolated or lonely in ways that put their health at risk. Recent studies found that:   * Social isolation significantly increased a person’s risk of premature death from all causes, a risk that may rival those of smoking, obesity, and physical inactivity (National Academies of Sciences, Engineering, and Medicine, 2020). * Social isolation was associated with about a 50% percent increased risk of dementia (National Academies of Sciences, Engineering, and Medicine, 2020). * Poor social relationships were associated with a 29% increased risk of heart disease and a 32% increased risk of stroke (National Academies of Sciences, Engineering, and Medicine, 2020). * Loneliness was associated with higher rates of depression, anxiety, and suicide (National Academies of Sciences, Engineering, and Medicine, 2020).   Progressive programs such as Family Care and Family Care Partnership require continued evolution of practice to help members build and nurture relationships, identify the caring and welcoming places in their neighborhoods and sustain the natural supports available to them within their community.  The long-term outcome of this initiative for members of the Family Care and Family Care Partnership programs is to experience the supports they need to achieve their desired level of active community involvement and improved satisfaction with the support they receive. They will understand their care teams are focused on person-centered planning tailored to their needs and will provide active support in minimizing barriers to achieving a personal sense of community connectedness. Members will live fuller, healthier lives through their connections to people and places within their community. | | | |
| X |  |  | 3. Summarize the MCOs collective internal and external future state for the Community Connections Initiative. |
| **Future State**  There are several factors both internally and externally that will affect the future state of this initiative. Lakeland Care believes the timing of this important initiative is opportune, given the fact that our communities are currently in the process of transitioning away from the social distancing that has taken place for the last two plus years. It allows the ability to focus on exploration, renewal and growth of community and social connections.  Internal  One important internal factor is the current focus on enhancement of person centered practices and member directed outcomes, both of which have been areas of focus in recent years. This initiative is well-timed as the MCO’s care management leaders and training teams look to deepen the person-centered philosophy, revisiting practices and developing resources to ensure a holistic approach to engage members on their interests and relationships to optimize a member’s sense of community connectedness. As such, the conversation around members’ skills, interests and roles in community now becomes a more significant part of conversation.  Although care Management teams have been using robust tools for conversation in the care planning process, it is critical for us to continue to evolve and enhance those tools while exploring best practices and sharing resources. One key area of focus will be enhancing education, exposure, and experience with what it means for members to have valued social roles within the community. Increasing knowledge and understanding of the definitions within this initiative of things such as authentic goals and valued social roles will require time, training and shifting of creative conversations with members to help them identify related goals and ultimately achieve their preferred level of community connections.  Often, members present with complex healthcare needs, family situations, or personally challenging situations, leading care teams to have an intensive and necessary focus on health and safety. Members’ health and safety will continue to be high priority; however, the timing of this initiative creates a vital opportunity to ‘reset’ and serve as a welcome pivot to a refreshed approach to member conversations and care planning.  External  There are external factors that impact this work, mostly in a positive way. Building Full Lives and Personal Centered Planning training by the Department of Health Services are examples of external factors that help to build interest and passion for re-evaluating means for improving the approach to exploring community connections with members. Further, the initiative builds on the work that MCOs have done with pre-vocational service providers to transition to a focus on community-based services. Other external factors to be considered include potential perceptions of members or families that this initiative is simply a cost savings measure. Such perceptions could hamper meaningful conversation around member’s interests, relationships and opportunities for connection and valued social roles. Lakeland Care will take this into consideration when developing conversation tools for care teams.  Societal norms exist, such as the expectation that service providers are to essentially be the community for people with disabilities. Increased participation by people with disabilities in communities will begin to shift that way of thinking while helping to build stronger, more diverse, and inclusive communities for all.  The aversion to member risk is an external factor that could have an impact. It will require a structure and contract that supports the dignity of risk, takes into account important individual considerations, and the adjustments necessary to modify a plan when needed.  Finally, one critical external factor related to the success of this initiative will be the availability of transportation options within each community.  MCOs’ collective experience with the Community Integrated Employment initiative reiterated the importance of engaging both provider and members early on. The asset map of stakeholders and concerned others provides excellent guidance relative to engagement, and points to the importance of comprehensive knowledge about assets in community. | | | |
|  | X |  | 5. Include description of MCO leadership involvement in the steering committee and implementation of the Strategic Plan. |
| **MCO Leadership Commitment** Lakeland Care understands leadership support and commitment is critical for successful project and change management. Pay for Performance initiatives require establishing a clear vision, communicating the vision with others, and resolving potential barriers and conflicts in carrying out the project vision.  Lakeland Care Community Connections Steering Committee is responsible to define project outcomes, provide advice and direction on the Strategic Plan, set project timelines, assist in monitoring project quality, and evaluate and monitor for risk. Lakeland Care Community Connections Steering Committee is comprised of the following personnel:   * Jen Harrison (Chief Operations Officer) - As Executive Sponsor, Jen will be responsible for ensuring the Community Connections P4P efforts are aligned with the overall organizational strategy, gathering support, communicating goals to senior executives, and providing ongoing direction to the Lakeland Care Community Connections Steering Committee during the P4P’s lifecycle. * Katie Calmes (Quality Director, Project Lead) – As Project Lead, Katie is responsible for effective planning, task coordination, overseeing project health, establishing, and maintaining an effective channel of communication with stakeholders, and collective decision making necessary for project implementation. * Jessica Quam (Care Management Practice Support Director, MCO Joint Committee Representative - Contract Language workgroup) – Jessica’s role in the Steering Committee is to assist in identifying practice gaps and barriers, strategies towards incorporating the Community Connections P4P into Lakeland Care practice, review of potential contract changes related to Community Connections, and overall training specifics. * Nathan Luedke (Data Analytics & EMR Applications Director) – Nathan is charged with ensuring Lakeland Care has the capability within the systems to gather, track, monitor, and evaluate the data elements necessary within the Strategic Plan. * Angela Beaty (Provider Relations & Contracting Director) – Angie will be responsible in communicating and collaborating with providers towards Community Connection aims, jointly brainstorming with providers on potential solutions to barriers, and sustaining efforts for the future.   The team members involved in the execution of this Strategic Plan include the Lakeland Care staff members serving on the Lakeland Care Community Connections Committee or serving on a workgroup committee. This includes:   * Stephanie Phillips (Care Management Best Practices Manager and MCO Joint Committee - Current Practice Workgroup, MCO Joint Committee -Training Workgroup) to assist efforts in conducting MCO self-assessment re. strengths, weaknesses, opportunities, and threats, assisting with evaluating and determining best practices to consider for practice, and determining and coordinating training experiences for Lakeland Care employees. Stephanie will be incorporating information and lessons learned from the recent NCAPPS Learning Collaborative\* * Alisha Andrews (Quality Risk Manager and Member Advisory Committee Facilitator) responsible for ensuring on-going Member Advisory Committee education, contribution, and support. * Carol Pautsch (Data Analytics Manager) role in developing systems collections, monitoring and analysis. * Katie Schultz (Quality Manager) role in collecting, analyzing, and monitoring data.   The existing Lakeland Care Member Advisory Committee and Oneida and Menominee Tribal Advisory Committees will be leveraged to support the Strategic Plan through their standing meetings and when necessary, as ad hoc. This will ensure that member and guardian/parent representatives, as well as Tribal partners are kept informed about the progress on implementation of the Strategic Plan and their feedback, suggestions, and ideas for increasing the success of the Community Connections P4P are captured and relayed back to the Project Lead as well as the Lakeland Care Community Connections Steering Committee.  MCO staff involved in leading and collaborating on the Community Connections P4P efforts shall prepare, in advance, a progress report on the Community Connections P4P for each meeting of the Lakeland Care Member Advisory Committee and Tribal Advisory Committees, including discussion questions to leverage the expertise and insights of the Member Advisory Committee. The Project Lead or designated Community Connections representative will present the progress report at each Member Advisory Committee meeting and Tribal Advisory Committee meeting, facilitate the discussion at the meeting, and provide that summary to Lakeland Care’s Community Connections Steering Committee and, as appropriate, to the joint MCO Community Connections P4P Steering Committee.  Lastly, Lakeland Care will be including the Care Management Advisory Committee in carrying out the Strategic Plan. The Care Management Advisory Committee is comprised of 14 Care Manager and 12 Nurse Care Manager representatives servicing all the Lakeland Care regions.  \*Of note, Stephanie Phillips and Katie Calmes participated in the 2022 Learning Collaborative Opportunity – National Center on Advancing Person-Centered Practices and System (NCAPPS). Over the ten sessions, Katie and Stephanie were introduced to the Nine Elements of Person-Centered Systems. Michael Smull and Associates tailored the sessions to focus on leveraging positive pressure for change, alignment of systemic processes and practices to create a person-centered system, and displayed how collaborative participants can lead and influence change within their organizations and system. | | | |
|  |  | X | 6. Include description of community member(s) and community-based organization (s) involvement in the steering committees and/or workgroups. |
| **Community Involvement**  Individually and collectively, MCOs will work collaboratively to engage a broad array of stakeholder representatives including members, family members, providers, advocacy organizations, and community-based organizations in the development of the Strategic Plan and in carrying out strategies within the plan.  Intended stakeholders and types of potential community connections partnering may include:   * Contracted Service Providers – Day Services, Adult Day Care, Daily Living Skills Training, and residential settings including Adult Family Homes (certified 1-2 AFH and 3-4 Licensed AFH) and Assisted Living Facilities (CBRF and RCAC) * Provider Associations – Wisconsin Coalition for Collaborative Excellence in Assisted Living, Wisconsin Assisted Living Association, etc. * Advocacy Organizations and Programs – Disability Rights Wisconsin (confirmed primary contact is Jean Jarosh), Wisconsin Board for People with Developmental Disabilities ((BPDD - confirmed primary contacts are Beth Swedeen, Kaitlin McNamara, and Shannon Web), Building Full Lives (contact is Shannon Web), ARC of WI, Wisconsin Institute for Healthy Aging, People First of WI, Disability Service Provider Network (primary contact is Lisa Davidson), etc. * Organized Community Groups/Events – Local Recreation Departments, Wisconsin Chamber of Commerce Executives Association, Senior Centers, VFW, Neighborhood Watch, Rotary, Boys and Girls Club, etc. * Specialized Group Organizations – City Councils, Superior Health Quality Alliance, NAMI, Alzheimer’s Association, SOAR, Down Syndrome Association of WI, etc. * Volunteer Services and Supports – Humane Society, Food Pantry, Library, etc. * Faith based Connections – local churches, community centers, etc. * Online Communities – Support Groups, Online Learning, etc. * Organized Sports – Special Olympics, Park and Recreation, Group Fitness, etc. * Education and Learning – College courses, Community Classes, CPR/First Aid Classes, Stress/Meditation Classes, etc. * Employment – DVR, CIE, etc. * Local Businesses – shopping centers/vendors, restaurants, etc.   Additionally, Lakeland Care Steering Committee representatives will be attending the 2023 engAGED and Commit to Connect: Social Engagement Virtual Summit being held in May 2023 and the Wisconsin Self-Determination Conference being held in October 2023.  Lakeland Care, as well as the other MCOs, will provide information and education to community members and community-based organizations as a foundation and introduction to the Community Connections P4P. The MCO Joint Community Connections Steering Committee has developed a Community Connections Pay for Performance Unified Plan correspondence as an initial communication to providers to share the MCOs commitment to a unified approach. MCOs will request commitment from community members and community-based organizations towards partnership and ongoing collaboration with the Strategic Plan efforts. Depending on the level of commitment, this may include review and input towards current barriers and limitations, opportunities for improving community connections, review and input towards education/informational materials, questionnaires, surveys, screening tools, and/or assessments, work group or committee attendance and participation, etc.  Lakeland Care provided an introduction of the Community Connections P4P to the Member Advisory Committee on 2/20/2023, and to the Oneida Nation Tribal Advisory Committee and Menominee Indian Tribe of WI Tribal Advisory Committee on 3/1/2023. The overview of the Community Connections P4P focused on the aim and goals of the project and the Strategic Plan requirements including Steering Committee makeup, national research, key data demographics, model of change, inventory of current practice, external stakeholder engagement, best practices, tools and system changes, training plan and associated due dates. The Member Advisory Committee and both Tribal Advisory Committees were in full support of Lakeland Care and the collective Family Care MCOs efforts with the Community Connections P4P. Additionally, the proposed DHS Member Satisfaction Survey questions focused on community connections were shared with the Member Advisory Committee and Tribal Advisory Committee Representatives for input and feedback. | | | |
|  |  | X | 7. Include description of how MCOs ensured the make-up of the steering committee is representative of the diversity of its membership. Include current steering committee membership demographic data to ensure diversity in representation that’s reflective of the MCO membership composition. |
| **Diversity of the Steering Committee**  Lakeland Care’s Community Connections Steering Committee is comprised of committee representatives with diverse backgrounds, experiences, and unique skill sets and ideas to bring to the Strategic Plan. As previously noted, the Member Advisory Committee is an active part of the Steering Committee with representation from members and legal representatives/family. With Lakeland Care’s composition of 50% of members in the ID/DD target group, 35% of members in the FE target group and the remaining 15% in the PD target group, the organization is committed to growing the Member Advisory Committee, specifically as it relates to Frail Elder and Physically Disabled representation. Lakeland Care solicits committee members through member newsletters, member satisfaction surveys, and through individual discussions by IDT staff. Additionally, Lakeland Care is including Tribal Advisory Committee representation in the Community Connections P4P. Lakeland Care’s Tribal partners are equally committed towards improving community connections for the membership.  Lakeland Care does not discriminate in enrollment and disenrollment activities between members based on age, disability, race, ancestry or ethnic background, religious belief or affiliation, sex or sexual orientation, life situation, condition or need for long-term care or health care services, etc. If warranted, Lakeland Care will solicit input and feedback ad hoc from additional members, legal representatives, families, etc. to ensure the diversity of representation. | | | |
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| **PART 1B:** **Strategic Plan Proposed Measures, Including Measures Research** | | | |
| **Section Description:**  This section summarizes the MCO’s research on measurement of the DHS Framework for Community Connections including measurement strategies for person-centered thinking, planning, and practices along with increasing members’ community connections and valued social roles. The purpose of measurement is to guide the decision-making process throughout the project life cycle and to evaluate if the objectives are met. Research should include:   1. Member and/or provider outcome-based measurement for monitoring and achieving meaningful community connections along with valued social roles. 2. Structural measures which are used to assess infrastructure of capacity, systems, and processes.   Process measures which measure what a MCO and/or provider does to maintain or improve an intended outcome. | | | |
| **Corresponding Contract Requirements:**  1) A summary of research on national measures, including research on measures of person-centered thinking, planning, and practices; increasing community connections; impact of community connections; and member and/or provider measurement for achieving meaningful community membership.  2) A definition of success, including proposed structural, procedural, and outcome-based measures for monitoring the initiative; whether the MCO is proposing the measure for monitoring initiative progress or recommends the proposed measure as a withhold or incentive criteria for 2024 and beyond; and the MCO’s capacity to obtain data for the proposed measures that includes demographic information like age, race, ethnicity, sex, primary language, or disability status. | | | |
| **Optional Section Resources:**   * [Measures Management System Structural Measures (cms.gov)](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Structural-Measures.pdf) * [Type of Quality Measures](https://www.ahrq.gov/talkingquality/measures/types.html) * [Person-Reported Outcome Measures for Home and Community-Based Services](https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbs-quality-measures-brief-2-person-reported-outcome.pdf) * [RTCOM Social Connectedness Measure Development Blueprint WORIKING DRAFT0 University of Minnesota](https://publications.ici.umn.edu/rtcom/briefs/brief-one-involving-stakeholders-to-address-challenges-in-hcbs-mesure-development) * [RTCOM Meaningful Activity Measure Development Blueprint WORKING DRAFT](https://publications.ici.umn.edu/rtcom/briefs/brief-three-development-of-hcbs-outcome-measures)   [University of Minnesota](https://publications.ici.umn.edu/rtcom/briefs/brief-three-development-of-hcbs-outcome-measures)   * [Improving Data Infrastructure for Patient-Centered Outcomes Research for People with Intellectual and Developmental Disabilities (hhs.gov)](https://aspe.hhs.gov/sites/default/files/documents/dab8370bf95a35d678e6968de86f9ecd/idd-opportunities.pdf) * [ICI Community Life Engagement-Guideposts Fidelity Scale-Draft](https://www.communityinclusion.org/files/cle-toolkit/guideposts_assessment_22.pdf) * The Rehabilitation Research and Training Center on HCBS Outcomes Measurement   [https://rtcom.umn.edu/](https://secure-web.cisco.com/1j3BjucsXex2mO6sDtpu8F3ILGObT0iJraRKQEyuZzieYtzh7cAaynVpHf25HbiocIBGSWxsA2kMDIl1AXZLo9L-bLK99EiVHo2NOVAyOZaLSq1y9MCKPaXER5bth-cC6dhWrjOfLo5_igweMrtIKZtOqwclNTRdj4y_-yB7xBTgN56Miqe2ClELROwW8GU78LK8wRkg0M1-hgYdPnYFU6eK7OzXtXbi-zj9T7lxPHnbxtCNH9fYdlAd5aeCuofuQfa7r8hCjuFZ_ptWbc23kglDpvKaFHoul5eHrvHwlaa32lruGgmPJXgcBdxy1-MKcCC3xkg8l_QARQZKPYCU2UA/https%3A%2F%2Frtcom.umn.edu%2F)   * Starfire of Cincinnati: [https://www.starfirecincy.org/](https://secure-web.cisco.com/17M7oxuZF2idA3fwvEaRvh_nS8b5xZDw3MK2SZanvboQv_mPg_78A0Oydh4rfds2ZV6xIhFR90IPWqj130IZQLfpRxzZ06YnqKJ7mAYQliCvlA--kRZuXKWU6SJwUmNJRgVuhrrZL646oFXjJFrpe33tBh2D47Qa8h19MQB_V9yyoJEvQ5FayY5Ig7hIaB1nCrYXEpT-039_hqks2DyWm2OzDOHzQ6agDPqNw5suiC-MUykZ9yut5CUqX8P0dk50bDmMSsnIlldhKNkBjBCDKdcgMalUy7bMG_ei8Sy3LCAJpwLni_bMEM1LQ5padQfL_/https%3A%2F%2Fwww.starfirecincy.org%2F) * Healthy Places by Design: <https://healthyplacesbydesign.org/socially-connected-communities-solutions-for-social-isolation/> * [Person Driven Outcomes: Opportunities for Your Quality Measurement - NCQA](https://www.ncqa.org/blog/person-driven-outcomes-opportunities-for-your-quality-measurement/) * July 21, 2021 (30” video): [Public Sector Briefing: Person-Driven Outcomes - NCQA](https://www.ncqa.org/videos/public-sector-briefing-person-driven-outcomes/) * Reported Outcome Measures development: [Patient Reported Outcome Measures (cms.gov)](https://www.cms.gov/files/document/blueprint-patient-reported-outcome-measures.pdf)   (Akin to MCO members’ Personal Experience Outcomes development – MCO Contract Article V.C.3 Member-Centered Planning)   * Link to final report of NQF work on HCBS measures development: [NQF: NQF Provides Guidance to HHS for Measuring the Quality of Home and Community-Based Services (qualityforum.org)](https://www.qualityforum.org/HCBS.aspx) * [What Does Community Inclusion Look Like-Community Inclusion Initiative -National Disability Service](https://www.nds.org.au/images/resources/resource-files/What_Does_Community_Inclusion_Look_Like.pdf) * Friends: Connecting People with Disabilities and Community Members A Manual for Families by Angela Novak Amado <https://ici.umn.edu/products/tpYWhm5tRHua0nutcqCX3Q> * Activity Worksheets Friends: Connecting People with Disabilities and Community Members A Manual for Families by Angela Novak Amado <https://ici-s.umn.edu/files/HfAqRd9pyQ/activity-worksheets-friends-families-11-15-19> | | | |
| Collective | Individual | Either | **MCO-Strategic Plan Components** |
| X |  |  | 1. Summarize analysis of research on national measures, including research on measures related to:    1. person-centered thinking, planning, and practices;    2. increasing community connections;    3. impact of community connections on members and the community; and    4. MCO, member and/or provider measurement for achieving meaningful valued social roles though community connection and membership. |
| **Person-Centered Thinking, Planning, and Practices**  The National Quality Forum (NQF) was asked by the Department of Health and Human Services’ (HHS) Administration for Community Living (ACL) and the Centers for Medicare and Medicaid Services (CMS) to put together a committee of people with lived and professional experience in long-term services and supports (LTSS) and acute, primary, and chronic care. The Committee’s goal was to give government agencies and the public a view that finds agreement across different partners and perspectives of how Person Centered Planning should be executed in practice. In July 2020, The NQF released a report titled, “Person-Centered Planning and Practice Report”, which is a summary of their committee work, providing a good baseline for PCP practices and outcome measures (National Quality Forum, 2020).  At the start of the NQF Committee work, there were not any standardized quality measures set for PCP nor a set of evidence-based strategies upon which to develop measures of PCP. Over the last several decades, advocacy groups for persons who are representative of the people who receive home and community-based services (HCBS) have emphasized the right to self- determination and the desire for individual self-direction of federal and state funded services and supports. Expansions in federal and state rules have reflected deeper governmental commitments to support these rights and opportunities. This work of defining and adopting standardized PCP measures is significant because it impacts a large part of our society. About sixty-one million Americans have disabilities; twenty-one million Americans are expected to be living with multiple chronic conditions by 2040; and many will require LTSS in community and institutional settings (Johnson, Toohey, & Wiener, 2007). More standardized PCP practices and outcome measurements will help ensure the overall quality of life for these individuals, thus contributing to more inclusive and healthier communities.  Background  The Affordable Care Act requires states that receive federal funds to develop systems that support independence and self-direction of people using HCBS (Guidance to HHS Agencies for Implementing Principles of Section 2402(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs, 2014). In January 2014, CMS published the HCBS Settings Final Rule, which included requirements on the PCP process and components of the individualized person-centered service plan for persons who receive Medicaid funded HCBS under certain federal authorities (Home & Community Based Services Final Regulation, 2022).    In 2014, NQF convened an expert multi-stakeholder group to develop recommendations for the prioritization of measurement opportunities that address gaps in HCBS quality measurement. One important gap identified is in measures that promote PCP and support community living. The final report identified PCP as an important domain and described it as, “The processes by which a person directs the development of a plan, based on his or her goals, needs, and preferences, and the coordination of services and supports across providers and systems to carry out the plan” (Trauma-Informed Approaches Practical Strategies for Integrated Care Settings, 2020). The 2020 NQF report is an extension of this previous work. Defining Person-Centered Planning The National Quality Forum, with input from the Committee, determined the following to be the best definition of PCP: “Person-centered planning is a facilitated, individual-directed, positive approach to the planning and coordination of a person’s services and supports based on individual aspirations, needs, preferences, and values. The goal of person-centered planning is to create a plan that would optimize the person’s self-defined quality of life, choice, and control, and self-determination through meaningful exploration and discovery of unique preferences and needs and wants in areas including, but not limited to, health and well-being, relationships, safety, communication, residence, technology, community, resources, and assistance. The person must be empowered to make informed choices that lead to the development, implementation, and maintenance of a flexible service plan for paid and unpaid services and supports.” (National Quality Forum, 2020)  Most of the research, programming, and best practices related to PCP and the Community Connections Initiative embraces the overall tenet of this definition. As more systems are making the shift from deficit-focused care planning to a person-centered planning approach, the concepts in the definition above are becoming more operationalized in practice. Where systems continue to struggle is how to create meaningful, standardized measures that will demonstrate that individuals who engage in PCP lead more independent and fulfilling lives.  Factors Needed to be Successful in Person-Centered Planning  In their 2020 report, the NQF acknowledges that PCP is not as simple as asking a few questions of service recipients and putting together a plan. There are many opportunities to forward this work and many barriers that need to be addressed. Some of the factors NQF outlines in their paper that will help make PCP successful are: (1) educating recipients and their personal support networks on the concept of PCP, (2) workforce training and competencies that prepare staff for quality PCP work, and (3) how the service delivery systems need to support PCP.  Here are examples of the key components of each factor stated above:   1. Educating recipients and their personal support networks 2. Person-centered planning takes a positive approach, meaning it is based on what and individual is good at or likes. 3. The talks individuals have in the meeting should be about their life, goals, dreams, needs, wants, things they like and do not like, and what is important to them. 4. Individuals are in charge of their plan and should/will be supported to lead the meeting as much as they would like. 5. Individuals are informed that in some situations, there might be limits placed on decision making. Their plan may be changed to make sure certain safety risks are considered and mitigated. 6. Workforce Competencies 7. Strength-based thinking 8. Active and reflective listening 9. Engagement 10. Negotiation 11. Advocacy 12. Knowledge of system resources, gaps, and barriers to plan development. 13. Service System Support of PCP 14. Leadership support, vision, strategy, and development of measurements. 15. Participant stakeholder engagement through advisory councils and other ways to gather regular feedback and input regarding PCP and service delivery. 16. Financial support includes funding to support participants in their plans but also related to workforce training, support, and capacity. 17. Establishment of state and federal regulations that reduce the barriers to quality PCP practices.  Person-Centered Planning and Practices Measure Framework Taking into consideration all the elements of quality PCP work, the NQF’s PCP Committee developed a framework for PCP and practice measure development. The Committee considered existing measures in the field, gaps in measurement, and the complexity and entities responsible for PCP from the person to the facilitator to the government system. The Committee scan resulted in 366 measures, 206 of which were relevant to PCP. These 206 measures fell into six broad categories: (1) experience of care, (2) frequency of interaction, (3) complex care, (4) care transitions, (5) communication, and (6) shared decision making. Per review of all the categories and measures in this paper, The Council on Quality and Leadership’s (CQL) Personal Outcomes Measures (POM) were most aligned and applicable to the current Wisconsin Department of Human Services (DHS) Managed Care Organization (MCO) Scorecards and developing measures for the Community Connections Initiative. CQL uses the measures to improve the quality of life for persons with disabilities and the service organizations that support them. The POMs include 21 indicators organized into five factors to address quality of life topics such as health, safety, social roles, rights, relationships, community integration, and employment, among others. These indicators align with measurement concepts central to PCP (The Council on Quality and Leadership - Tools, 2020).  In addition to CQL, Multidimensional Assessment of Providers and Systems (MAPS) is a research program to inform the assessment of services and supports for adults with intellectual/developmental disabilities in Ontario, Canada (Martin, Ouellette-Kuntz, & Cobiog, 2013). Their work revealed that person- directed planning (PDP) is more than planning, planning meetings, or plans. PDP is a way of supporting persons with intellectual and developmental disabilities (IDD) that brings us one step closer to fulfilling the aspirations of “normalization.” They describe PDP as being about the redistribution of power from the system to adults with IDD and natural support (i.e., family, friends), the relationships between the people involved in planning, and the communities that are created.  The National Center on Advancing Person-Centered Practices and Systems (NCAPPS) released a paper in 2019 entitled, “Person-Centered Thinking, Planning, and Practice: A National Environmental Scan of Indicators.” (Person-Centered Thinking, Planning, and Practice: A National Environmental Scan of Indicators, 2019) Their Human Services Research Institute conducted a national review of indicators that may be used to assess person-centered principles in aging and disability systems, including mental health systems. The intent of the review was to determine a set of indicators that could gauge the degree to which these principles are being implemented.  In this paper, they took the main themes of PCP and created seven domains that included several indicators for each domain that could help assess whether PCP work is successful in each domain. For example, the domain of “Community Participation” is described as: *People have support to participate in and to be members of their communities and are treated as equal members in their communities.* The indicators for this domain are: (1) People take part in community activities, (2) People do not experience barriers to taking part in activities in their community, and (3) People are treated equally and with respect in their communities. Although these indicators are congruent with what each PCP domain should look like in practice, executing the concepts and measuring them in day-to-day practice is a challenge as mentioned in other papers we reviewed. Some of the gaps identified in this paper included: (1) the planning process and how to measure whether an individual has an active and valued role in determining their goals, (2) accessible information that truly measures an individual’s meaningful role in the plan beyond a staff interaction report, and (3) continuity of supports, specifically being able to measure whether supports are delivered in a coordinated way not just that they exist.  NCAPPS proposed a slightly different definition of person-centered planning. It is a way to learn about the choices and interests that make up a person’s idea of a good life – and to identify the support (paid and unpaid) needed to achieve that life. It is not something that you do to a person, nor is it something you do for a person; instead, it is directed by the person, with support from a facilitator as needed and desired. There is a description of five competency domains: (1) strengths-based culturally informed, whole person focused, (2) cultivating connections inside the system and out, (3) rights, control, and choice, (4) partnership, teamwork, facilitation, and coordination, and (5) person-centered plan documentation, implementation, and monitoring (Person-Centered Thinking, Planning, and Practice: A National Environmental Scan of Indicators, 2019).  Data & Measurement Challenges  Outcome data related to PCP measures is still in its infancy stages and any results or outcomes are based on small samples of participants, their families, stakeholders, and communities. In some cases, the research is narrowed to a particular population such as individuals with disabilities or the aging population who may have more medical challenges. The research regarding PCP measures suggests similar categories or indicators but currently, there is not one standard set of measurements that would provide consistency in how each measure is defined, data collected and at what score is an accepted best practice. What is consistent thus far are the concepts of giving an individual choice in how they want to live, what kind of care they should receive, who they want involved in their care plan and how they want to be involved in their community. In addition, more recent research has focused on the competencies of the workforce to be able to engage recipients in PCP conversations and to develop PCP plans.  The research also acknowledged the culture of the service delivery system and the tolerance within communities to support PCP play a role in the overall outcomes.  Recognizing the lack of consistency in national PCP measures, the National Opinion Research Center (NORC) at the University of Chicago prepared a report for The Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health & Human Services. This report, issued in July 2022 and entitled, “Improving Data Infrastructure for Patient-Centered Outcomes Research for People with Intellectual and Developmental Disabilities”, focuses on short-term opportunities for improving the patient-centered outcomes research (PCOR) data infrastructure that addresses the needs of individuals with intellectual and developmental disabilities (ID/DD) (The Office of the Assistant Secretary for Planning and Evaluation , 2022). (Note that this report is tailored to a specific population so may not include recommendations for other populations like the aging who are also in need of long-term care). The information and feedback gathered for this report was based on interviews and listening sessions with federal agency representatives, researchers with expertise in ID/DD, service providers, individuals with lived experience and non-federal stakeholders. The interviewees are defined in this paper as “key informants.”  The top three opportunities that were identified in this report to better standardize PCP measures include:   1. Standardize the collection of ID/DD status at the point of care through development of standards and policy changes to promote their adoption 2. Address gaps in standardized outcome measures important to individuals with ID/DD 3. Support the development of robust data linkages programs for Transformed Medicaid Statistical Information System (T-MSIS) data and other federal data sources.   Of particular interest as it relates to the Community Connections Initiative, the gaps in standardized outcome measures identified in number two above include: (1) abuse, neglect, harm and exploitation – specifically related to under-reporting and how that impacts the ID/DD population overall, (2) justice involvement – specifically regarding outcomes for the ID/DD population upon reentry to the community following incarceration, (3) quality of life and well- being – focusing on strengths and choice versus deficits, and (4) employment as it relates to income levels of the ID/DD population and the accommodations made in the workforce. All the gaps identified may be important to take into consideration as Wisconsin implements Community Connections. Number one and two above speak to the risk factors that may need to be considered when planning for a more integrated community life. Numbers three and four are opportunities for members to thrive in their communities through choice and assess how the community may or may not openly receive the ID/DD population.  In addition, the data collection gap is critical to understanding the overall functioning and quality of life for the ID/DD population. Key informants noted that current outcome measures are outdated, lack cultural sensitivity, and do not capture domains that are meaningful to individuals with ID/DD. Addressing gaps in person-centered outcome measures for the ID/DD population would help researchers to better understand how individuals with ID/DD experience the services and supports they receive, their level of engagement with services, and how the services impact their lives. Since standardized PCP measures have not yet been developed, the conclusions from this report and the feedback from key informants can be utilized to help the Wisconsin MCOs develop measures that are meaningful to members by asking the right questions during member and stakeholder feedback sessions.  The NCAPPS paper also outlined a summary of how different sources that were seeking to create PCP indicators were gathering their data (Person-Centered Thinking, Planning, and Practice: A National Environmental Scan of Indicators, 2019). This is also a critical piece to consider because each method of data gathering has its own challenges with validity, reliability, and participation. The data gathering included in-person interviews, self-assessments, electronic surveys, and mailings. All these tools have inherent gaps or challenges from ensuring appropriate reading levels for individuals to worker bias in how questions may be asked and documented. These data collection challenges will be critical to identify as Wisconsin establishes our PCP measures and outcomes and how that information will be collected from various sources.  Conclusions  Although there is a lack of standardized PCP measures, there is consistency in how data is collected via participant and stakeholder interviews and questionnaires (stakeholders being defined as family members, member-identified supports, employers, service providers, community leaders, etc.). This is similar to what Wisconsin is already gathering from MCOs to develop the MCO Scorecards. That said, there are some inherent challenges with the reliability or validity of the data collected depending on how it is administered and the participation level of members. Revisiting how the current data is collected in terms of actual questions and processes would be a way to assess whether MCOs are really capturing a member’s full experience with service delivery and community life. Risk factors, potential biases, and types of populations (ID/DD, aging, etc.) should also be taken into consideration when refining any measurement tools and data.  **Increasing community connections**  Another key factor of successful PCP work that is gaining specific attention is the concept of community connections (also referred to in other systems or publications as “community inclusion,” “personal opportunities” or “meaningful activities”). There is a plethora of research available that indicates that people who are more involved in their communities, social activities, meaningful friendships and feel they have a social valued role, are less isolated, have less incidence of depression and have an overall better quality of life. Likewise, when people with IDD are given opportunities to make more choices, they develop greater self-determination (Wehmeyer & Garner, 2003).  More commonly though, people with IDD have limited opportunities to make their own choices, to participate in desired activities, or to fully engage in their communities in ways that are typical for people without IDD, making opportunity, in its own right, an important outcome for people with IDD (The Office of the Assistant Secretary for Planning and Evaluation , 2022).  As with PCP, the ability to measure the outcomes of community connections is not yet standardized and to date, the research has just begun. Depending on the population being served (IDD, aging, physically challenged, etc.), there is not going to be a “one size fits all” measure. How measures are developed, surveys administered and community barriers to access and inclusion are considered, the Community Connections Initiative will take some time and advocacy to realize its full potential. That said, there is a good foundation of research to help guide Wisconsin in providing individuals with choice in how they more actively participate in community life.  In 2021, The University of Minnesota’s Rehabilitation and Research Training Center on HCBS Outcome Measurement (RTC/OM) in collaboration with Temple University, the University of California-San Francisco, The Ohio State University, and the National Council on Aging, released a working draft paper entitled, “Meaningful Activity Measure Concept - Measure Development Blueprint.” The purpose of the blueprint and measure concept is to provide information to advocacy and self-advocacy organizations, home, and community-based service (HCBS) providers, program administrators, and policymakers regarding the personal outcomes experienced by persons who are the recipients of HCBS.  The blueprint defines meaningful activities as: “those activities that are important, enjoyable, and/or valuable to the individual and the activities can be instrumental or functional, social and/or cultural, and recreational or leisure-type with different levels of physical demand.” This definition excludes work-related or employment-based activities. Although important, work-related activities involve a separate set of goals and measures. This definition was derived from other research, including The National Quality Forum (NQF) who reference that meaningful activity is approached as the level to which individuals who receive HCBS engage in desired activities (e.g., education, volunteering, recreation, leisure, etc.) (Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement , 2016).  The measure concept of meaningful activities is designed to capture the responses from the following questions:   1. How important/valued is each type of activity for individuals who receive HCBS? 2. To what degree do people get to engage in activities that are meaningful to them? 3. For individuals who received HCBS, how enjoyable/satisfied are they in participating in each type of activity? 4. From the perspective of individuals who receive HCBS, to what extent do people get enough support to engage in these types of activities? 5. To what extent does the level of support provided by HCBS encourage the participants to be as independent as they can?   The target population for the Meaningful Activity measure concept includes persons with physical disabilities (PD), intellectual or developmental disabilities (IDD), traumatic brain injuries (TBI), mental health (MH) conditions, and individuals with age-related disabilities (ARD) and chronic illness, who receive HCBS supports associated with meaningful activities. This is a broader population base than some of the research related to PCP, for which each paper or research project was targeted to a more specific population. Since the Wisconsin MCOs serve an array of adult populations with many diverse needs, these measures may be more applicable overall.  The Meaningful Activity measures are divided into two tiers – one tier is considered “global” and the other “specific.” Global measures are intended to gain a broad understanding of each measure concept. An example of a global measure would be: “You participate in activities that are meaningful to you.” This is then answered on a rating scale. The specific measures are intended to gain more detail of activities and may include some actionable information. An example of a specific measure would be: “Activities that include physical activity are meaningful to you” (Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement , 2016).  Another important aspect of item development is to identify suitable item formats and response options to capture the construct intended to be measured. The meaningful activity concept measure is being designed to capture five important aspects of the construct: (1) value of activity, (2) level of engagement, (3) level of satisfaction, (4) level of support by HCBS, and (5) level of support to be independent. In addition, how each measure is worded or presented to a member should take into consideration any cognitive, developmental and/or physical disabilities that member may have. This does make standardized measures a bit more complicated, but the data will also be compromised if individuals do not understand the items. In another publication entitled, “Measuring Four Personal Opportunities for Adults with Intellectual and Developmental Disabilities,” this study tested an empirically derived model for measuring personal opportunities for people with IDD using National Core Indicators In-Person Survey (NCI-IPS) state and national datasets. The four personal opportunities measured, (a) privacy rights, (b) everyday choice, (c) community participation, and (d) expanded friendships, were informed by existing conceptualizations of service as well as NCI-IPS measures (Prohn, Dinora, Broda, Bogenschutz, & Lineberry, 2022).  The most significant finding of this study, which is not surprising, was that the level of IDD impacted the personal opportunities of the individual. With each increase in level (e.g., mild compared to moderate IDD), indicators of personal opportunity typically decreased. This inequitable access to opportunities between people with various levels of IDD demands that HCBS and other service systems review their procedures and make direct efforts to minimize disparities. In addition, and not a surprising finding, where an individual lived also made a difference in their ability to be more involved in their community and/or develop personal relationships outside of formal support, family, or the individuals with whom they live. Opportunity measures provide systems with a mechanism to further identify, and address disparities based on a range of characteristics such as race, urbanicity, co-occurring behavior and health conditions, to assure increased equity among people who use support and services to participate in their communities.  In another paper entitled, “Is Belonging in Community an Elusive Goal for People with Intellectual and Developmental Disabilities?”, recommendations to increase and measure community integration was provided based on the same or similar research stated above (Hamlet, 2019). The program initiatives recommended are: (1) promote employment, (2) expand relationships, and (3) increase self-advocacy. With respect to the Community Connection Initiative in Wisconsin, employment has already been an active initiative with the MCOs so that will not require additional discussion here. Regarding expanding relationships, the special considerations included, (1) providers focus on expanding social networks, (2) increase community engagement, (3) educate on healthy relationships, and (4) cultivate reciprocal relationships. There was also a caveat that the level of IDD, mental health as well as any history of abuse or other trauma, needs to be a salient factor in promoting community participation. Again, care plans should be individualized to meet the desires of the individual but also take into consideration personal or community risk factors.  Regarding increasing self-advocacy, the paper suggested that this is another way for individuals to be less reliant on formal support and to feel good about who they are even if they feel “different” from others in the community. Education and training for staff regarding the social limitations of those with IDD as well as continued conversations with recipients about what barriers they are experiencing and how that feels for them, will only help with knowing how to best direct self-advocacy efforts.  One example of taking the concepts of community integration and community connections and creating action is the development of the activity worksheets in the “Friends: Connecting People with Disabilities and Community Members: A Manual for Families” that was developed by the Research and Training Center on Community Living, Institute on Community Integration (UCEDD), at the University of Minnesota (Amado, 2013).  This manual provides activities for families to help them connect themselves and their child or loved one with disabilities to community life. The exercises explore relationships, interests, places that would be welcoming and how to start up new friendships/relationships to help build a plan of action. Although not research or outcome-based now, this is an example of providing a tool to families and individuals with disabilities to start the process of increased community integration. This is a great resource to begin building measures of how positive community connections could be defined and measured by gathering feedback from those with lived experience about what is or is not working.  Conclusions  Measures for community connections for the populations served by MCOs, like PCP measures, are still in their infancy stage. The results of the research regarding being connected to community as a way to stave off feelings of isolation, depression and negative self-worth are significant. In addition, the research regarding the additional complications and barriers for individuals with IDD, chronic mental health issues and the aging populations’ ability to participate as they desire in the community, is also worth noting. The work to ensure that community connections are at the forefront of care plans is critical, but the process needs to be thoughtful due to potential risk factors for some members. That said, the ability for MCOs, service providers, families, and other stakeholders to embrace community connections will take time and advocacy from all parties involved, including government. Some communities are not rich in opportunities, transportation or tolerance based on race, age, and disability. For community connections to be successful, there needs to be actions and initiatives occurring simultaneously from working with an individual all the way up to working with an entire community or region to ensure safe and enriching opportunities.  **Impact of community connections on members and the community**  As referenced in the above sections, the ability to measure the outcomes of community connections has not been standardized. Understanding the impact of community connections for members as well as the barriers that exist related to inclusion and community connections will take time, intentionality, and advocacy to realize its full potential. There is some information and research on measures to consider as Wisconsin looks to ensure that we are providing individuals the opportunity to integrate as they desire in their communities.  Social connectedness has been shown to have a direct relationship with mental and physical health and even mortality rates, such that better social connections are associated with better health and longer lives. Indeed, Holt-Lundstad (Holt-Lunstad, Robles, & Sbarra, 2017) frames improving social connectedness as a public health issue as important as addressing obesity, physical inactivity, and air pollution. This is a wide range of research to collaborate this belief with the general population.  The degree to which individuals are connected within their communities has a powerful impact on their health and wellbeing. Knowledge in this area is based on a range of approaches for conceptualizing and measuring social connectedness including social network analysis; level of social support; and level of social engagement/isolation. One of the key challenges of this literature is disentangling the effects associated with various aspects of low social connectedness (Berkman L.F., 2014).  Relationships, be they with biological or chosen family, friends, or spouse/partner, produce a sense of belonging. Relationships are personally defined, ranging from who one chooses to share information with to a deep level of intimacy and familiarity. CQL believes relationships create links to the greater world that establish a blanket of security and help people who receive support play social roles. In the CQL national data, people performing different social roles were one of the least frequently achieved outcomes (The Council on Quality and Leadership - Tools, 2020).  All these findings have strong implications for service delivery and policy development. Primarily, social connectedness must be recognized as a factor in overall health for people with disabilities, and service providers and medical professionals should consider this facet of people’s lives as much as they consider other demographics and social determinants of health. Humans are wired to connect, and this connection affects our health. The opposite of connection, social isolation, has a negative effect on health and can increase depressive symptoms as well as mortality (Martino, Pegg, & Pegg Frates, 2015).  The building of relationships and connections is the focus of smaller initiatives such as Starfire in Cincinnati, Ohio, Involving All Neighbors in Seattle, WA., Citizen Advocacy in Savannah, GA., PLAN and Building Caring Communities in Vancouver, BC (Building Inclusive Communities in Seattle: Involving All Neighbors, 2019). These initiatives aim to uncover a person’s talents and passions to connect with others so they can thrive in their communities alongside their neighbors. There is much qualitative information available and though the quantitative research is lacking, there have been many tools developed to assist staff and others to learn about strategies for building connections such as Friends: Connecting people with disabilities and community members (Amado, 2013). In each of these projects the starting point is the gifts (skills, passions, and knowledge) of the members and shifting power to the individual to identify desired lifestyle. Each adopted the philosophy of Asset Based Community Development (ABCD) incorporating tools such as community asset mapping. ABCD is a community development approach that focuses on identifying and leveraging the strengths, resources, and capacities of individuals, organizations, and communities to create positive change. The approach is based on the idea that people, community members, are experts on their own lives and communities (McKnight J. L., 1996).  In these projects there is an emphasis on looking at who and where people spend their time. By focusing on the gifts of the person and looking at opportunities for connection and community, attention to social infrastructure is crucially important, because local face to face interactions are the building blocks of all public life. People forge bonds in places that have healthy infrastructures – not because they set out to build community, but because while people were engaged in sustained, recurring interaction, particularly while doing things they enjoy relationships inevitably grow (Klinenberg, 2018).  There is research from other community institutions in the US that have adopted a community engagement / connecting approach. Twenty-two libraries or museums participated in a two to four year community catalyst initiative. The summary of the Community Catalyst Initiatives produced considerations for stakeholders: the considerations for capacity builders being most applicable to the community connections project (ORS Impact, 2021). These include:   1. Align capacity-building supports to meet project teams where they are 2. Offer more opportunities for discovery, applied practice, and experience 3. Focus on the process not the products of capacity building 4. Leverage peer learning to deepen capacity and practice development.   The P4P community connection has a direct relation to communities and relation to shifts in models of community development. Current models of community development increasingly center practice that shifts control of decision making and agenda-setting from institutions (where it is most traditionally held) toward those most affected by—and nearest to—a given community issue. In the community development field, there is a growing recognition that community members’ lack of control, authority, and power over the critical economic, social, education, and public health issues they face is a root cause of unhealthy communities (Pastor, Ito, & Wander, 2020).  In Socially Connected Communities - Solutions for Social Isolation (Social Isolation Learning Network with support from the Robert Wood Johnson Foundation, 2021), lists abundance thinking as a priority in their guiding concepts for creating socially connected communities. Abundance thinking is a mindset that focuses on assets and what is possible, rather than on deficits and pitfalls. It is the belief that there are enough resources, creativity, and wisdom to meet our needs, and that we can achieve more tomorrow than we can imagine today.  One promising way to create socially connected communities may be to recognize, celebrate, and reinforce assets which are inherent in local communities and social support systems. For example, an asset-based approach might amplify stories of how a group has overcome marginalization. It is also important to acknowledge and support the fact that every resident and neighborhood has assets and the ability to lead their own change. For community-based organizations and social service providers there is the recommendation to devise programs that encourage socializing and include needed support from transportation to coaching for people to participate and that policy makers weave social connectedness and community centered processes into every policy, practice, development, and investment they influence.  In Solutions for Social Isolation: What We Can Learn from the World, the authors highlight the need to elevate inequity as a root cause of social isolation, noting, “People who experience inequities and are isolated from opportunity because of where they live, how much money they make, or the color of their skin more often experience social isolation. Addressing inequities should be at the front and center of all efforts to strengthen social connectedness.” (Social Isolation Learning Network with support from the Robert Wood Johnson Foundation, 2021)  Conclusions  There has not been an intentional focus on community connecting at a statewide level but there is much learning from smaller initiatives in the US and elsewhere. These initiatives often adopted a strengths or asset-based framework such as ABCD as a framework for a cultural shift to the gifts of individuals and the assets in community. Attention to the process was highlighted as a critical element in addition to the time required to develop the skills and shift in philosophy. There have been tools developed that could be incorporated into conversations, planning and training.  **MCO, member and/ or provider measurement for achieving meaningful social roles through community connection and measurement**  Research shows that the performance of a variety of social roles in community settings correlates significantly with measures of other valued outcomes (especially measures related to choice, personal growth, and health and safety), but that it is among the most difficult outcomes for service organizations to achieve (Gardner & Carran, 2005).  SSR: Supporting Social Roles (O'Brien, 2010) is a framework for thinking about and measuring social roles in community. SSR proposes that over time, effective organizations will support a growing proportion of people in valued roles in a growing number of settings outside of disability services. These roles are valued when they attract respect, facilitate contribution, engage gifts and capacities, and hold the possibility of belonging. O’ Brien contends that SSR sets a higher bar than a satisfaction survey because people can be satisfied even when a service could do more to assist them to overcome social exclusion.  The SSR tool provides a structure to examine performance of social roles in 8 community settings and a guide for examining the roles and dreaming what could be.  There are other ways to measure such as PASSING (Wolfensberger & Thomas, 2007) or Personal Outcomes Measures. Critiques of The PASS and PASSING instruments focused attention on all that was wrong with a particular service or a whole service system. And while that naming of what needs to change is an important first step – it is even more important to envision a better present and future with a way to get there (Lemay, 2007).  SSR: Supporting Social Roles correlates with person centered practices as most people find some sectors of community life more engaging than others, so most profiles are irregular based on the gifts and goals of each person.  The initiatives highlighted in 1c. primarily collected stories and utilized tools such as relationship maps (Amado, 2013) for measurement. All began with a gift-based lens (McKnight & Block, 2010), to identify the gifts (skills, interests, and passions) of the person. Then each made connections to groups and others in community that often included social roles based on those skills, capacities, and gifts of the individual (McKnight & Block, 2010).  Conclusions  Although there is little research on measurement and social roles the tools that have been developed such as SSR and relationships maps could be useful in identifying possibilities and measurement with attention to the goal of community connecting activity is to build relationships rather than turning friends into volunteers or “over-programming” and formalizing friendship (Amado, 2013). | | | |
| X |  |  | 2. Propose at least 2 measures for each measure type (structural, procedural, and outcome-based measures or indicators) to determine how the success of the initiative will be measured. |
| **Cohort Determination**  Each MCO is responsible to gather the potential cohort listing of members enrolled 11/1/2023 – 9/30/2024 in the FE, PD, and ID/DD target groups, who are being served in a non-residential setting. This list will be the closed list of potential members for the CY2024 CC P4P.  MCOs will conduct a significantly sound sampling of members enrolled (confidence level of 90% and margin of error at +/- 5%) – static sampling to begin 11/1/2023. Exclusions will be determined after sampling.  Target Population - Eligible Members  Criteria for the proposed 2024 starting cohort include eligible members who meet all the following eligibility criteria:   * Enrollment Status: Active Family Care or Partnership member enrolled prior to or on 11/1/2023. * Not in any of the following exclusion categories on 11/1/2023:  1. Members living in any long-term care facility as defined by the Family Care contract (a nursing home, adult family home, community-based residential facility, or a residential care apartment complex) 2. Members who moved to a residential setting for more than 90 days 3. Members without a permanent address 4. In hospice: Member who is receiving hospice services 5. In a hospital 6. In an institutional setting: Member is in an institutional setting and is expected to remain until the end of 2023. Institutional settings include: 7. Skilled Nursing Facility 8. Intermediate care facility for the Intellectually Disabled (ICF-ID) 9. Institute for Mental Disease (IMD) 10. Medically compromised**:**     1. Member is in the PD target group at the Intensive Skilled Nursing Services (ISN) levels of care (highest needs) per the LTCFS.     2. Member is in I/DD target group and is eligible for No Active Treatment per the LTCFS. 11. Member with Approved Restrictive Measure(s) or court ordered restrictions   Future Cohorts  Future cohorts to be determined by 11/1 each year.  **Proposed Measurements**  Structural:  MCO has a training plan for IDT and providers, develop training curriculum for IDT.   * 1A. Develop a training plan for IDT. * 1B. Develop a training plan for appropriate cohort contracted providers. * 1C. Develop training curriculum for IDT.   Structural:  MCO has an established mechanism to gather, monitor and evaluate data specific to the identified cohort and the implementation of project activities.   * 2A. Gather information through systems and stakeholder solicitation. * 2B. Monitor information through systems and reporting mechanisms. * 2C. Evaluate information through analysis.   Structural:  MCO develops and maintains a data collection system that includes, for each member, demographic that may be used to ensure equity for all participants. (Age, race, ethnicity, primary language, and target group)  Procedural:   * 4A. Cohort members are assessed on their Community Connections interest level. * 4B. Interested cohort members have a related outcome on their plan. * 4C. Cohort members are reassessed every 6 months.   Procedural:   * 5A. Percentage met and implements training plan for current IDT and new hires. * 5B. Percentage met and implements training plan for appropriate contracted providers. * 5C. Collect cohort member satisfaction level in current community connections.   Outcome:   * 6A. Increase the percentage of cohort members active in inclusive community life and civic engagement (measured by progress toward, increase from initial assessment, or increase % of interested level “current participating”). * 6B. Increase or maintain cohort member satisfaction with community connection. * 6C. Increase or maintain IDT competencies. * 6D. TBD through ongoing P4P evaluation and stakeholder engagement. | | | |
|  | X |  | 3. For each of the proposed measures: describe each MCO’s current baseline capacity to stratify data by demographic information including at minimum: age, race, ethnicity, sex, primary language, and target group (frail elders, physical disability, and intellectual/developmental disability). |
| **Baseline Capacity**  Lakeland Care currently has the capacity to stratify data by demographic information including at minimum: age, race, ethnicity, sex, primary language, and target group. Data sources include TruCare, Lakeland Care’s electronic member record software; the DHS Long Term Care Data Warehouse to access Long Term Care Functional Screen data; and potentially Lakeland Care’s Data Clarity, a web-based software system to support workflows and hosts information for enrollment, claims and provider management. Additionally, Lakeland Care has the capacity to include the demographic information listed above in conjunction with the proposed cohort criteria. | | | |
| X |  |  | 4. For each proposed measure included whether for each year, 2024 to 2027, the measure is proposed for monitoring initiative progress, as a withhold criterion, or as an incentive criterion. |
| **Proposed Measure Criterion**  The measure identification by year and criterion are proposed as:   * 2023   + measures 1A, 1B, and 1C identified as structural-based and already defined by the Community Connections withhold for 2023. * 2024   + measures 2A, 2B, and 2C proposed as structural-based and potential withhold criterion. * 2024, 2025, 2026, and 2027   + measure 3A proposed as structural-based and potential incentive criteria.   + measures 4A, 4B, 4C, 5A, 5B, and 5C proposed as procedural-based and potential monitoring criterion. * 2025, 2026, and 2027   + measures 6A, 6B, 6C, and 6D proposed as outcome-based and potential incentive criterion. | | | |
|  |  | X | 5. For each proposed measure also include whether it is recommended that MCO or DMS collect the proposed data element(s). There may be a mix of MCO and DMS measurement proposed but there must be MCO collected data elements included in the proposal. |
| **Data Collection**  Each MCO would be responsible to collect all data elements for each proposed measure included in the Strategic Plan. | | | |
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