**Community Connections**

Pay For Performance 2023

Lakeland Care Inc, Individual Strategic Plan

Individual MCO Proposal Resubmission September 2023

Part 2: C, D, and E

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**Community Connections**

Pay For Performance 2023

Lakeland Care Inc, Individual Strategic Plan

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

This document contains individual Lakeland Care 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.

|  |  |  |
| --- | --- | --- |
| **Data Categories** | **Data Specifics** | **\*per 100 enrollees** |
| Non-Institutional Living | Members in own home or apartment | 55.89 |
| Members receiving supported home care | 38.70 |
| Non-Institutional Living – Members in residential settings | 1-2 Bed AFH | 3.34 |
| 3-4 Bed AFH | 7.06 |
| CBRF < 8 people | 5.59 |
| CBRF > 8 people | 19.83 |
| RCAC | 3.36 |
| Institutional Living | Number of members in SNF (nursing home) | 4.92 |
| Number of members in Centers (FDD/ ICF-IDD) | 0.01 |
| Daytime Services | Prevocational services community-based | 7.84 |
| Prevocational services facility-based | 0.15 |
| Daily living skills training – home and/or community | 1.48 |
| Adult day care – facility based | 1.01 |
| Consumer education and training | 0.61 |
| Day habilitation services | 10.59 |
| Counseling and therapeutic resources | 14.99 |
| Transportation – community specialized non-medical | 14.57 |

The total expenditure amount for CY 2022 for Non-Institutional Living was $273,062,700.54 and for Institutional Living it was $30,501,249.73.

Summary of Data

Lakeland Care primarily used encounter data to determine the above utilization data as well as create the baseline. The exception was the use of authorization data to determine the living setting. Lakeland Care anticipates continued use of encounter and authorization data to monitor changes in paid services. It is anticipated that through continued montioring and evaluation, some existing authorizations processes may need to be modified depending on the needs of the project.

The Data Analytics and Applications teams are currently developing a natural support needs assessment tracking system to capture data specific to member’s who have natural supports assisting them. It is anticipated that the system will be ready to pilot in Q2 2024 and monitoring reports of the tracking system to be available shortly after implementation.

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

Lakeland Care’s current practice incorporates community connections and valued social roles through the Comprehensive Strength-based Assessment, member-specific Member Care Plan, and care coordination efforts.

Assessment

Lakeland Care recognizes a person is more likely to engage in goals and plans when the individual understands how the plan relates to his/her own hopes, wants, beliefs, life goals, and priorities. Additionally, individuals can experience great benefit when they are encouraged to use his/her inherent strengths and resources to best meet his/her needs and overcome challenges. Lakeland Care’s Comprehensive Strength-based Assessment includes the availability and stability of natural and community supports for any part of the member’s life; including an assessment of what it will take to sustain, maintain, and/or enhance the member’s existing supports and how the services the member receives from such supports can best be coordinated with services provided by Lakeland Care. Furthermore, the assessment includes an exploration with the member of his/her preferences and opportunities for community integration including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community.

Lakeland Care’s Comprehensive Strength-based Assessment includes over 34 assessment questions related to community connections. Key assessment categories include: Community Integration, Culture & Religion, Social History & Support, Transportation, Education, Vocation, Financial Management, and Quality of Life.

1. Community Integration
   1. Member’s preferred leisure time activities in their community
   2. Member participates in a day service program; includes details, support, level of supervision, satisfaction with current services
   3. Member volunteers in the community; includes details
   4. Member typically accesses the community; frequency options include daily, weekly, every other week, monthly, other
   5. Can safely and independently access the community AND independently participate in preferred community activities (including leisure activities, community events, etc.)
   6. Can safely and independently cross a street
   7. Makes safe and independent judgements regarding who are safe people to talk to/receive assistance from when in the community
   8. Understands/demonstrates ability to appropriately perceive and respond to a threat when in the community
   9. Understands/demonstrates ability to respond appropriately if lost when in the community
   10. (For individuals with an ID/DD), has individual ever gone into the community by themselves; if no, does the member wish to explore increasing independent community access
   11. Member indicates having the help / support needed to participate in desired leisure activities
   12. Member indicates having the ability / supports in place to access the community as desired
   13. Member specific community integration preferences identified
2. Culture & Religion
   1. Any particular religious or spiritual preferences identified (practices, type, etc.)
   2. Affiliated with a church, synagogue, or other religious community
   3. Member has religious beliefs or practices that may impact their medical decision?
   4. Member identifies with a specific ethnic/cultural heritage
   5. Any particular ethnic/cultural practices and/or preferences that are important to member (including long-standing family practices)
   6. Member has cultural beliefs or practices that may impact their medical decisions
3. Social History & Support
   1. Member feels they have enough contact with family and friends
4. Transportation
   1. Member requires assistance with transportation; includes details
   2. Able to coordinate own transportation needs
   3. Uses adaptive equipment when accessing the community; includes details
   4. Requires physical assistance accessing transportation; includes details
   5. Member uses the following types of transportation to meet needs; bike, bus, natural or community supports
5. Education
6. Currently enrolled in school
7. Member interested in attending school / classes
8. Vocation
9. Employment Status; includes type and details as well as supports and details
10. Member is currently seeking or is interested in finding employment (includes new or additional employment, if employed); includes type interested in, assistance in finding/applying (and support plan)
11. Member is participating in Project SEARCH
12. Any specific employment preferences identified that have not been addressed
13. Financial Management
    1. Member’s level of assistance with money management
    2. Member’s support and support details
    3. Member has understanding of financial transactions
    4. Member has adequate income to meet their needs and maintain their current living arrangement
    5. Any known money management concerns
14. Quality of Life - These are optional in the Assessment
    1. How important is it to you to have regular interaction with family and friends?
       1. Very
       2. Somewhat
       3. Not at all
       4. Non-Response/ NA
    2. How important is it to you to participate in work or other meaningful activities (including preferred alone time, maintaining hobbies, preferred activities, etc.)?
       1. Very
       2. Somewhat
       3. Not at all
       4. Non-Response/ NA
    3. How important is community involvement to you (consider participation in clubs, social groups, and accessing entertainment, shopping, restaurants, church, etc.)?
       1. Very
       2. Somewhat
       3. Not at all
       4. Non-Response/ NA

**Care Plan Objectives**

Lakeland Care’s Care Plan includes the below topics related to community connections. Each member’s Care Plan is unique with member-specific long-term care outcomes and personal experience outcomes. Based on the Comprehensive Strength-based Assessment, the Care Plan includes the goals, strengths, preferences, barriers, and interventions important to the member.

1. Environmental
   1. Feels safe in their home
   2. Is happy/satisfied with current living arrangement
   3. Living environment is safe (free of health hazards, safety hazards)
   4. Home environment is accessible related to current needs
   5. Independent with one or more IADL
   6. Feels living situation is stable (is not worried about losing home, not in a temporary living situation, etc.)
   7. Has reliable transportation (able to get to appointments, work, etc.)
   8. Other environmental strength
2. Financial / Legal
   1. Feels has adequate finances to pay their bills.
   2. Able to manage finances independently
   3. Pays bills timely
   4. Has prepared for future needs (created appropriate POA documents, life planning)
   5. Other financial/legal strength
3. Social / Supports
   1. Able to participate in family events as desired
   2. Caregivers demonstrate minimal to no caregiver strain/stress
   3. Caregivers utilize supports to maintain/reduce healthy outlook
   4. Feels has desired / enough contact with family and/or friends
   5. Feels has the help they need to meet their needs.
   6. Feels is treated with respect by those around them
   7. Feels relationships are healthy and supportive (feels safe with family, caregivers, etc.)
   8. Has natural supports who assist with household tasks and/or maintaining home environment in a positive manner
   9. Treats others with respect
   10. Other social / support strength
4. Spiritual
   1. Feels people around them value their beliefs/values
   2. Able to participate in spiritual / cultural activities that are important to them.
   3. Feels they have meaning and purpose in their life
   4. Receives practical and/or social support from church or spiritual group
   5. Other spiritual / cultural strength
5. Vocational
   1. Enjoys their work
   2. Is interested in working & is actively pursuing employment
   3. Participates in preferred hobbies
   4. Involved in their community (volunteers, attends community events, civic participation, etc)
   5. Actively participates in care planning process
   6. Is happy with level of involvement in care planning process
   7. Feels has support needed at work.
   8. Other vocational strength

In reviewing Lakeland Care’s current practices, additional data is needed to determine the overall effectiveness of the current practices. While both the Assessment and Care Plan account for community connections and valued social roles, the Care Plan in particular, has previously not been specific with community connections goals. In general, members have wanted to elect to focus on health- and safety-related goals with preferences noted in the above categories. Lakeland Care anticipates with IDT staff education and training, along with member education, the Care Plan can be adapted to include Community Connection P4P specifics.

Lakeland Care conducted the National Center on Advancing Person-Centered Practices and System (NCAPPS) Person-Centered Practices Self-Assessment among 13 employees in various roles within the organization as an additional current practice review. This Self-Assessment is designed to help organizations measure their progress in making human services systems more person-centered. The Self-Assessment can be used by the wide range of systems that oversee services and supports for people with disabilities of all ages, older adults with long-term service and support needs, and other health and social service programs. The Self-Assessment is divided into eight sections; Leadership, Person-Centered Culture, Eligibility and Services Accesses, Person-Centered Service Planning and Monitoring, Finance, Workforce Capacity and Capabilities, Collaboration and Partnership, and Quality and Innovation (Bourne, 2022).

The results of the average scores on the NCAPPS Person-Centered Practices Self-Assessment are displayed in the chart below. The top scored focus areas include Finances and Person-Centered Service Planning and Monitoring. The area showing opportunity for improvement efforts was Collaboration and Partnership. Lakeland Care Leadership views this self-assessment as a worthwhile continuous improvement activity and will be expanding the number of employees completing the self-assessment. The intention is to continue to complete the self-assessment periodically, to gain a sense of where current efforts are advancing and where there remain opportunities in working towards greater levels of person-centered practices.

Additionally, to help combat social isolation and loneliness amongst the Lakeland Care membership, Lakeland Care has collaborated with Pyx Health. Pyx Health is a combination of compassionate humans and a simple, interactive mobile app that assists members in connecting with the right type of resources to manage their well-being. Pyx Health does not replace the Care Team; it provides additional support when needed or wanted any time, 24 hours a day via an app or phone call during Pyx Health business hours. Lakeland Care members have options available to them such as companionship calls and engaging activities focused on their emotional and physical well-being. Pyx Health can also provide support for improved mood, anxiety, motivation and more. Pyx Health does not cost anything to the members and is a voluntary option.

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

These current barriers were identified and elaborated on by both individual MCOs and as a collective. The collaborative compared the list to the SWOT summary to determine what is similar and different from MCOs and what is in and out of the scope of the P4P. The current barriers identified were divided into categories of Community, Providers/Stakeholders, MCO, and Members.

**Communities**

There is a potential barrier that there will be a lack of community acceptance. Assumptions, preconceived notions, and bias remain obstacles for those with disabilities to overcome. The goal is to continue to provide communities and the general public more information about individuals with disabilities, but not all members have the social skills necessary for navigating the social aspects of forming community connections. Lakeland Care and providers within the network will continue efforts in providing training and education for members to best grow that skillset, however, this will continue to be time-intensive and for some, may be a lifelong goal.

Another challenge is a lack of accessibility for those who require accommodations to freely access their communities. This can include family and friends’ homes that are not accessible. Several Lakeland Care members take advantage of warmer weather to be able to freely access their communities (such as farmers markets, community theatre, musicals, etc) and homes of friends and family, however, Wisconsin’s seasonal changes typically run a longer colder season in comparison to the warmer season. Several communities Lakeland Care serves have begun to transition community-based gatherings and activities to indoor, accessible venues or holding the events outdoors, however, there remains significant gaps in members being able to freely access their communities.

**Providers**

Statewide, the provider network remains significantly challenged by staffing shortages. Since COVID, providers have seen a decrease in staffing and have not recovered. There has also been a lack of interest from the workforce despite providers recruitment efforts. With the rising costs in the economy, the general workforce is electing to work where the wages are more competitive and where they can experience consistent staffing patterns; where employees can end their shift without having to accommodate for vacancies, etc. Due to limited staffing for all providers this will create barriers for supporting members in doing the activities they have interest in. It will be hard for providers to get members into the communities while maintaining member safety with members simultaneously in communities and at facilities.

Providers also struggle with transportation. Many providers no longer have their own facility vehicles and rely on having staff that have a license, insurance, and a reliable vehicle. If providers do not have a vehicle or staff to rely on, they are forced to use public transportation which comes at a higher cost for the provider.

**MCOs**

As for MCOs, the barriers are yet to be finalized depending on the final outcomes of the Strategic Plan. Community integration is a cornerstone of Family Care; therefore this may not have a large impact on practice as much as a recommitment towards community integration, community connections, and civic engagement. However, there is the potential for increased workload related to time investment in education, resources, coordination, support to members, their supports and contracted providers, additional documentation for tracking purposes, etc. If done properly could engage IDT staff and MCO employees at a renewed level. If not done thoughtfully and efficiently, an increase in workload could result in compassion fatigue, burnout, and IDT staff turnover. The impact of IDT staff turnover is directly felt by members, families, providers, and communities who support the membership.

In addition to the impact on IDT staff, MCOs must deploy several resources to plan, implement, evaluate, and monitor a Pay for Performance project of this size.

**FC Contract**

Barriers pertaining to the Family Care Contract are the lack of funding for this project. Many community activities that individuals participate in have a cost associated. Currently, the Family Care contract does not support most funding for true community activity costs. Because members have limited incomes, they often do not have funds left for community activities.

Currently, the Family Care contract does not allow for MCO’s to contract with Uber/Lyft (or other rideshare) transportation options. Rideshare opportunities can increase member’s autonomy and ability to access the community when they desire. These options would allow our members to have more transportation options for community activities outside of business hours.

**Members**

Members are often dependent on the MCOs, providers, and communities for support in meeting essential needs. For example, a member’s community may not have public transportation, so they reach out to their MCO for support. Due to the general staffing shortages, the MCO may not be able to find a provider to support the member for that day of the week, time, or date. Members also experience other barriers, often outside of their control, such as continued fears related to health (post-COVID), limited monetary resources, access, or ability to research opportunities in the community per individual preferences, etc.

Lakeland Care is mindful of the potential impact of previous negative experiences and past trauma resurfacing for some members. These member-specific situations have the potential risk for past trauma to be triggered.

The Wisconsin weather can also be a barrier for members during certain times of the year. Because members have a more limited access to transportation they often need to wait outdoors and on bus lines, increasing exposure to elements. The weather and related barriers may also deter them from attending community activities.

As more members start accessing the community, the need for transportation will increase. In current state, it is difficult to find transportation without planned advance notice. The increase will likely amplify the already existing limited transportation for members wanting to get out into the community as medical rides will take priority for the transportation providers. There is also a barrier with a lack of transportation providers having after business hours availability. Many of the community activities happen after business hours or on weekends and members will struggle to find transportation to these events.

Lastly, there is the barrier of some guardians, advocates, and organizations that still believe if a setting is more restricted it implies more safety for the member. This belief will restrict some of our membership in accessing their community and the activities they would like to participate in.

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

|  |  |
| --- | --- |
| **Strengths**   1. Local:  * We live in the communities we work; familiar with what our local communities have to offer * Able to see what is effective in one county/location and how to replicate in another county/location  1. Company Culture:  * P4P aligns with our mission, vision, and values * P4P aligns with LCI’s value of Employee Strengths and Member Strengths  1. Strong leadership commitment  * Leadership commitment helped ensure CIE P4P success & PIP success  1. Available Resources:  * Specialty Supports includes Behavioral Health, SDS, Community Integration, CIE, Transportation Associates, and Best Practice/Training  1. Member Centered Practices:  * Lakeland Care’s Quality of Life Assessment questions, member specific PEOs and Member Centered Plans provide foundation for P4P  1. 5 Star Quality:  * Continued 5 Star Quality on EQR * High Member Satisfaction  1. Pxy Program:  * Lakeland partner for social isolation/loneliness  1. Volunteer Program:  * Lakeland employee volunteer program – giving back to the community  1. Lakeland Care’s Size:  * Smaller size allows Lakeland to be nimble and respond quickly | **Weaknesses**   1. Transportation:    * Limited transportation providers    * Most transit provides service Monday-Saturday thus limiting weekends when most community activities occur    * In need of support/caregiver while using transportation services 2. Decrease of enrollments into FC and rise in IRIS 3. IDT staff turnover:    * Frequently changes in IDT staff due to FMLA leaves or vacancies compared to pre-pandemic    * Impacts the IDT staff’s ability to build trust, rapport, and reassurance as to who to go to for help 4. Policies and Guidelines:    * Policies are not necessarily user friendly and could provide more philosophy, rationale, and more on PCP 5. Inconsistent practices/messaging:    * Miscommunication between offices and teams    * Certain practices are not through the PDSA cycle so there is a lack of overall improvement 6. Organizations size & footprint:    * Can limit what we have available in our network and ability to meet member preferences 7. Community Connections Development:    * Requires a system of services/support that we currently do not have the infrastructure established 8. Complexity of members    * Members present with more challenging conditions or life situations |
| **Opportunities**   1. Increase use of SDS programming and highlight how it could be utilized with the P4P 2. Expand caregiving resources and educational opportunities: Research shows that caregivers have little to no professional resources 3. Workforce Shortages:  * Workforce shortages impacting more than just caregiving – impacting residential, supportive home, transportation, DLST, etc. as well as medical field, trade services, supply chains, etc. * Weekend support/caregiving is limited * Lack of member community connections/engagement due to shortage of caregivers or understaffed programming * Caregiving is a less chosen career field compared to pre-pandemic * Continued steady growing demand/need * Consistency low pay despite providers increasing wages (e.g. can make significantly more money working local shops, etc. than wages of caregiver) * High turnover rate (especially for ID/DD population); emotional and physical strain. * Increased strain on families who are forced to fill the gaps; public health issue  1. Grants and other funding opportunities 2. Use of Lakeland vehicles for volunteer services towards member activities | **Threats**   1. Community acceptance:  * Ensure our members are welcomed and accepted; not looked down on for their disability or age * Not all members have the social skills for community connections * Concept of doing with vs. doing for  1. Contract restrictions:  * FC/DHS Contract and Rates need to be revised to accommodate funding P4P  1. Inflation is causing member’s extra money going towards basic needs 2. Community facilities & family homes that are still not accessible 3. COVID is still a threat (medically vulnerable population) 4. Wisconsin weather limitations 5. Some guardians, advocates, organizations believe that if a setting is more restricted, it implies it is safer. |

# 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.

## Must include detailed strategy description including which goal(s) and objective(s) the strategy(s) meets.

## 

## All goals and objectives must have a corresponding strategy.

## An objective may have multiple strategies.

## Must include how health equity considerations will be infused into each strategy.

## How the MCO will evaluate the success of the chosen strategy.

## Identify which strategy is for the 2024 Specific Incentive Plan

## Include detailed process requirements for how the strategy will be implemented in 2024 included the specific responsibilities of the IDT staff.

**Lakeland Care Objectives, Strategies, and KPIs [combined section #3 and #4]**

Health Equity Considerations: For all Lakeland Care measures, health equity will be supported and encouraged based on the person-centered assessment and planning to ensure alignment of meaningful outcomes for each member. If members are expressing barriers related to health equity (race, ethnicity, sexual orientation, disability, financial status, etc.), IDT staff and providers will work with the member to advocate for their ability to participate in desired activities when appropriate. IDT and provider training content will introduce and align practice in support of health equity for each member.

For Incentive 1, Requirement 3, Lakeland Care is utilizing the Collective Objective 2. For Incentive 1, Requirement 1, Lakeland Care is utilizing Individual Goal 2 Objective B. For Incentive 1, Requirement 2 and 4, Lakeland Care is utilizing Individual Goal 2 Objective B.

In preparation for the Community Connections P4P, Lakeland Care provided training on the LCI Clinical Guideline – Social Determinants of Health (SDOH) Social Risk Factors Screening in July 2023. This was the final implementation cycle of the 2022 Nonclinical PIP: Improving Social Risk Factor Screening Through Member Education and Self-Assessment. LCI’s SDOH Screening Tool was developed in accordance with CMS’ Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool and adapted to meet organizational needs. The Social Risk Factor (SDOH) Screening tool consists of thirteen sections: Living Situation, Food, Transportation, Utilities, Safety, Financial Strain, Employment, Family and community support, Language, Physical Activity, Substance Use, Mental Health, and Disabilities. Each section has at least one question regarding the member’s needs in that specific area. LCI’s SDOH Screening Tool is modeled after this vetted version and includes only slight modifications and additional questions relevant to LCI’s membership.

Lakeland Care intends on utilizing the SDOH Screening Tool and additional baseline data related to barriers, especially health equity and access, to analyze for any themes and determine the appropriate plan of action within the scope of the contract.

**Objective A:**

Lakeland Care has three (3) Quality of Life questions of the Comprehensive Assessment that are geared towards community connections. These questions have been included in the Comprehensive Assessment since 2019 when Lakeland Care’s began utilizing TruCare as the electronic member record system. These questions are currently optional. Baseline data from the projected cohort (recognizing the cohort will likely change between submission of the Strategic Plan and the P4P Implementation), the Quality of Life questions were completed 86-87% for the projected cohort members.

The three (3) Quality of Life questions are:

* Quality of Life Question #1: How important is it to you to have regular interaction with family and friends? Response Options: Very, Somewhat, Not at all, Non-Response/NA
* Quality of Life Question #2: How important is it to you to participate in work or other meaningful activities (including preferred alone time, maintaining hobbies, preferred activities, etc.)? Response Options: Very, Somewhat, Not at all, Non-Response/NA
* Quality of Life Question #3: How important is community involvement to you (consider participation in clubs, social groups, and accessing entertainment, shopping, restaurants, church, etc.)? Response Options: Very, Somewhat, Not at all, Non-Response/NA
  + Responses for all three (3) Quality of Life questions that are marked as Very or Somewhat includes a details section for IDT staff to add member-specific details.

A graph of a number of people

Description automatically generated

Of the projected cohort members who responded to the questions, it is evident they value interactions with family and friends with a high ‘very’ response of 84%. Lakeland Care is hoping through interventions within the PDSA cycles to increase the percentages in the ‘somewhat’ and ‘very’ question related to meaningful activities and community involvement. Before improvements can occur or be determined as effective, it is necessary that care teams are engaging members in dialogue surrounding the Quality of Life questions and capturing the member’s responses to the questions. Lakeland Care intends on using the Quality of Life questions as supporting evidence when determining true improvement.

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| **Strategic Plan Goal 1 – Incorporate standard Community Connections identification and support into the Family Care and Family Care Partnership member assessment and planning process.** | |
| **Lakeland Care Objective A:**  90% of Lakeland Care members’ Comprehensive Assessments will include three (3) Quality of Life questions related to community connections from 1/1/2024 to 12/31/2024.  The three (3) Quality of Life questions are:   * #1: How important is it to you to have regular interaction with family and friends? * #2: How important is it to you to participate in work or other meaningful activities (including preferred alone time, maintaining hobbies, preferred activities, etc.)? * #3: How important is community involvement to you (consider participation in clubs, social groups, and accessing entertainment, shopping, restaurants, church, etc.)?   Strategies in meeting the Objective:   1. Strategy 1: Lakeland Care will modify the Comprehensive Assessment and Reassessment within the electronic member record system (TruCare) to require the three (3) Quality of Life questions.    * Measure of success of strategy: The three (3) Quality of Life questions will be required fields (no longer optional) that IDT staff must enter member responses. 2. Strategy 2: All IDT staff will be trained on the requirement of administering the three (3) Quality of Life questions to the member at the Comprehensive Assessment and Reassessment.    * Measure of success of strategy: IDT staff will accurately complete the Quality of Life questions. | |
| ***KPI 1:*** The number of member records with the three (3) Quality of Life indicators completed during the member’s Comprehensive Assessment and reassessment. | |
| **Numerator** | Number of member records with all three (3) Quality of Life indicators completed during the member’s Comprehensive Assessment and reassessment. |
| **Denominator** | Number of member records with the Comprehensive Assessment and reassessment completed. |
| **Inclusion/ Exclusion Criteria** | Inclusion Criteria: Members must be enrolled greater than thirty (30) calendar days of enrollment date to ensure a Comprehensive Assessment is completed.  The rationale in having all members’ Comprehensive Assessment and Reassessment to include the Three (3) Quality of Life questions is to ensure that IDT staff continue to support community connections efforts regardless of a member’s cohort.  This data will also be used for comparison data to the cohort data. |
| **Sampling Technique and Confidence Interval** | N/A |
| **Internal MCO Data Collection Frequency** | Continuous |
| **Method for Data Collection** | Lakeland Care IDT staff will complete the three (3) Quality of Life questions from the Comprehensive Assessment and Reassessment with the member’s responses. Members responses that are marked as Very or Somewhat includes a details section for IDT staff to add member-specific details.  Reports will be generated from the TruCare system at the above noted frequency. |
| **Data Stratification** | Stratification by member demographic information. |

**Objective B:**

Lakeland Care recognizes that effective care management requires time management skills and tools. The success of the Community Connections P4P hinges on the IDT staff’s ability to engage the member in dialogue, help spark interests, uncover opportunities, etc. as it relates to community connections and civic engagement all while facing competing work demands and attention to member specific needs. Lakeland Care intends on providing time management guidance for members within the cohorts through use of the TruCare Program option. TruCare Program assignment will be modeled after Lakeland Care’s CIE TruCare Program. With the TruCare Program option, Lakeland Care can select and assign cohort members to better track, and trend data, provide task reminders to IDT staff, and ensure accurate data collection for reporting needs. In instances where a member must now be excluded from that particular cohort, the member is reassigned to a different TruCare Program which helps to sustain clean data.

Initial feedback from Lakeland Care’s MAC, providers, and other stakeholders on efforts towards making the project a success was to continue to use a member specific approach as much as possible. The Community Connections Interest Inventory (the MCO collective tool) may not be able to meet all member’s needs. To account for this and offer the IDT staff options to best meet the member’s needs, Lakeland Care has chosen to train IDT staff on three (3) additional tools:

* Temple University Community Participation Measures (TUCPM): The purpose of the TUCPM is to measure a member’s participation in community activities (26 examples are provided) and the importance of the activities to the member.
* Head, Heart, Hands: This activity can help members identify their own gifts and what they have to contribute, to connect with other people with shared interests, and to find out what gifts other people have to contribute. It encourages thinking about gifts in three categories:
  + Gifts of the head: knowledge or information a person has; things that they know about and would enjoy talking about, or teaching others about e.g. local history, films, birds, or theology.
  + Gifts of the hands: practical skills; things that a person knows how to do and enjoy doing e.g. carpentry, football, gardening, or cooking.
  + Gifts of the heart: passions or skills, like listening; things individuals care deeply about e.g. protection of the environment, music, community life, or children.
* Community Mapping: Community Mapping encourages members to identify the assets of their neighborhood and communities, looking at opportunities and creating a picture of what it is like to live there and how they like to engage within their communities.

One advantage of the TruCare Program is that based on the tools chosen, data can be pulled and analyzed to determine effectiveness. It is hoped that through the PDSA cycles, Lakeland Care can further identify the best tool(s) to utilize on an ongoing basis and eventually incorporate into the TruCare system.

Lakeland Care is utilizing Strategic Plan Goal 2, KPI 1, KPI 2, and KPI 3 for the 2024 Incentive.

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| **Strategic Plan Goal 2 – Identify opportunities for member-specific, meaningful Community Connections for Family Care and Family Care Partnership members.** | | | |
| **Lakeland Care Objective B:**  80% of cohort members assessed as ‘Interested in developing community connections: Knows desired activity/connection’, ‘Interested in developing community connections: Unsure of desired activity/connection’, or ‘May be interested in developing community connections’, will complete a follow up activity within 90 days from 1/1/2024 to 12/31/2024.   * Strategy 1: For those members that express a desire or may be interested in developing community connections: IDT staff will initiate a follow up activity with the member within 90 days from the member completing the Interest Inventory.   + Follow Up activities may include:     - Temple University Community Participation Measures (TUCPM),     - Head, Heart, Hands, or     - Community Mapping   + Measure of success of strategy: Cohort members who expressed a desire or interest via the Community Connections Member Interest Inventory will have a documented activity completed. * Strategy 2: IDT staff will complete follow up activity tasks as part of the TruCare program.   + Measure of success of strategy: TruCare Program tasks for cohort members will be completed. | | | |
|  | ***KPI 1***: Interested Cohort members who complete the TUCPM as a follow up activity to further assess their community connection interests. | ***KPI 2:*** Interested Cohort members who complete the Head, Heart, Hands as a follow up activity to further assess their community connection interests. | ***KPI 3:*** Interested Cohort members who complete the Community Mapping as a follow up activity to further assess their community connection interests. |
| **Numerator** | Count of interested cohort members who completed the TUCPM. | Count of interested cohort members who completed the Head, Hearts, Hands activity. | County of interested cohort members who completed the Community Mapping activity. |
| **Denominator** | Count of interested members in cohort. | Count of interested members in cohort. | Count of interested members in cohort. |
| **Inclusion/**  **Exclusion Criteria** | Inclusion: All members in cohort who were assessed as ‘Interested in developing community connections: Knows desired activity/connection’, ‘Interested in developing community connections: Unsure of desired activity/connection’, or ‘May be interested in developing community connections’ from the Interest Inventory. | Inclusion: All members in cohort who were assessed as ‘Interested in developing community connections: Knows desired activity/connection’, ‘Interested in developing community connections: Unsure of desired activity/connection’, or ‘May be interested in developing community connections’ from the Interest Inventory. | Inclusion: All members in cohort who were assessed as ‘Interested in developing community connections: Knows desired activity/connection’, ‘Interested in developing community connections: Unsure of desired activity/connection’, or ‘May be interested in developing community connections’ from the Interest Inventory. |
| **Sampling Technique and Confidence Interval** | None | None | None |
| **Internal MCO Data Collection Frequency** | Continuous | Continuous | Continuous |
| **Method for Data Collection** | TUCPM activity scanned within the member record; Case note documentation | Head, Hearts, and Hand activity scanned within the member record; Case note documentation | Community Map activity scanned within the member record; Case note documentation |
| **Data Stratification** | Stratification by member demographic information. | Stratification by member demographic information. | Stratification by member demographic information. |

**Objective C:**

Member satisfaction surveys can prove to be an invaluable tool and measurement for an organization and organizational goals. Going beyond a survey’s results yield an opportunity to identify an organization’s strengths and weaknesses from a [customer’s perspective](https://www.thebalance.com/defining-and-measuring-customer-brand-experience-2296834). A satisfaction survey or evaluation is “a realistic tool to provide opportunity for improvement, enhance strategic decision making, reduce cost, meet patients' expectations, frame strategies for effective management, monitor healthcare performance of health plans and provide benchmarking across the healthcare institutions” (Al-Abri & Al-Balushi, 2014). Lakeland Care views the member satisfaction survey as a unique conversation with the membership; this open feedback from the members communicates what members want and need from an MCO, as well as, what type of support members’ desire to strive towards their long term outcomes. With survey results as a guide, it is how effective Lakeland Care listens and responds to the membership’s feedback that determines the success of improvement efforts in guiding practice changes to enhance the relationship between the members and the care teams.

Since 2018, DHS has conducted the Family Care (FC) and Family Care Partnership Member Satisfaction Survey. The survey is sent to a random sample of FC and FC Partnership members within each MCO; typically mid-July and results are calculated and evaluated early the following year. Question eight (8) inquires, “How well does your Care Plan support the activities that you want to be doing your community, such as visiting with family and friends, working, and volunteering?” Figure 1 displays the 5 years comparison of the Industry and Lakeland Care for the Top 2 Boxes or T2B (the percentage of respondents who selected the two most positive options (Survey Monkey, 2022). The T2B options are Extremely and Very.

*Figure 1: 2018 – 2022 Lakeland Care and Industry T2B ((positive responses)) ‘Extremely or ‘Very) to the DHS Member Satisfaction Survey question, “How well does your Care Plan support the activities that you want to be doing your community, such as visiting with family and friends, working, and volunteering?”*

The first three (3) years the question was included in the Member Satisfaction Survey, Lakeland Care yielded results higher than the Industry average. Since 2020 (post-pandemic), Lakeland Care’s T2B results were slightly under the Industry by less than one percentage point. Both percentages remain in the low 70’s, suggesting room for improvements.

With member satisfaction being a key element of success for the P4P, Lakeland Care will be focusing on the Community Connections Member Interest Inventory responses to the question “Currently, how satisfied are you in participating in activities within the community?” as a gauge towards improvement. The advantage of soliciting member satisfaction via the C, is that this will be completed for the cohort members prior to the implementation and after the implementation of the Care Plan changes. The DHS Member Satisfaction Survey is a reliable tool for the industry, however, with the delays in the data and sampling, Lakeland Care wanted to ensure the specific cohort members data was captured and available at minimum every six (6) months. While the satisfaction survey question and the Community Connections Member are not identical, they both allow for member voice as to community connections and level of satisfaction.

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| **Strategic Plan Goal 3 – Increase or maintain the percent of Family Care and Family Care Partnership members self-identifying as being active and having meaningful Community Connections.** | |
| **Lakeland Care Objective C:**  Cohort member’s six month level of satisfaction with their community connections involvement will be maintained or increased by 2% in the T2B (Top 2 Boxes); Very Satisfied and Satisfied from the initial Community Connections Interest Inventory from 1/1/2024 to 12/31/2024.   * Strategy 1: For cohort members, Lakeland Care will modify the Comprehensive Assessment and Reassessment within the electronic member record system (TruCare) to include the Community Connections Member Interest Inventory as a requirement. This will be developed through the Community Connections Program; this allows for task assignments, reminders, and allows for secured cohort data collection.   + Measure of success of strategy: The Community Connections Member Interest Inventory is applicable for the cohort members via the TruCare Program. * Strategy 2: All IDT staff will be trained on the requirements of the member Interest Inventory.   + Measure of success of strategy: IDT staff will accurately complete the Community Connections Member Interest Inventory as part of the TruCare program. | |
| ***KPI 1***: Percentage of cohort members with T2B maintained or increased by 2% on the Community Connections Interest Inventory. | |
| **Numerator** | Count of cohort members with reported satisfaction levels in the T2B (Top 2 Boxes); Very Satisfied and Satisfied |
| **Denominator** | Count of members in cohort who responded to the member satisfaction question. |
| **Inclusion/**  **Exclusion Criteria** | Inclusion: All members in cohort who completed the Interest Inventory and answered the member satisfaction question “Currently, how satisfied are you in participating in activities within the community?”  The Interest Inventory responses for the member satisfaction question include: Very Satisfied, Satisfied, Unsure, Dissatisfied, or Member Refused |
| **Sampling Technique and Confidence Interval** | Exclusions will be determined before sampling.  MCOs will conduct a significantly sound sampling of members enrolled (confident level of 90% and margin of error at +/- 5%) – static sampling to begin 11/1/2023. |
| **Internal MCO Data Collection Frequency** | Continuous |
| **Method for Data Collection** | Community Connections Interest Inventory completed every six (6) months. |
| **Data Stratification** | Stratification by member demographic information. |

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

Health equity will be supported and encouraged based on the person-centered assessment and planning to ensure alignment of meaningful outcomes for each member. If members are expressing barriers related to health equity (race, ethnicity, sexual orientation, disability, financial status, etc.), IDT staff and providers will work with the member to advocate for their ability to participate in desired activities when appropriate.

MCO Collective Objective 1: MCO IDTs are prepared to conduct and maintain competence in conducting member assessments and planning related to Community Connections.

## 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

Lakeland Care will utilize the current Virtual Meeting Attendance Report that tracks IDT staff attendance in virtual meetings.

Lakeland Care will develop an excel tracking report to capture each IDT staff’s pre- and post- training assessment scores.

## how the MCO plans to engage with their members

Lakeland Care plans to engage with members by individual efforts and mass communication efforts. Individually, IDT staff will engage members in dialogue about community connections, civic engagement, etc. at the time of introducing the Community Connections Interest Inventory (reference slide 36 from the Lakeland Care Community Connections Training Curriculum). Mass communication efforts include community connection related articles in the Lakeland Care Member Newsletter, sent quarterly to the membership.

## timeline(s) and detail description(s) of what the new development(s) or modification(s) will involve

Development of the pre- and post- training assessment scores report will be created in September 2023 in preparation for the October, November, and December Lakeland Care Community Connections IDT training sessions. Additional report specifics will include IDT staff discipline, date of pre- and post- training assessment scores, office location, CM Supervisor, and Program Manager, etc. This will allow further analysis if there appears to be a trend within an office location, by CM Supervisor, etc.

## 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.

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

PDSA cycles will determine if the implementation tools and system changes are effective.

Health equity considerations incorporated into the system for Objective 1 include gathering data on member demographic data, including age, race, ethnicity, language, sex, gender identity (when applicable), and disability status as a valuable tool for quality improvement.

Lakeland Care Objective A: 90% of Lakeland Care members’ Comprehensive Assessments will include three (3) Quality of Life questions related to community connections from 1/1/2024 to 12/31/2024.

## 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

Lakeland Care will modify the Comprehensive Assessment and Reassessment within the electronic member record system (TruCare) to require the three (3) Quality of Life questions that are currently optional.

## how the MCO plans to engage with their members

Currently, between 86-87% of Lakeland Care members have responded to the Quality of Life questions. This is a high percentage of members willing to share their levels of importance/value on the questions that are related to community connections. IDT staff will engage with members during their Assessment and Reassessments as to the Quality of Life questions.

## 

## timeline(s) and detail description(s) of what the new development(s) or modification(s) will involve

Configuration changes request was submitted and anticipated to be available by October 31, 2023, and ready for implementation Q1 2024.

IDT staff will be trained on the required Quality of Life questions during one of the three Community Connections Training Series; the series will be held October, November, and December 2023.

## 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.

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

Lakeland Care does not anticipate any further changes or improvements related to Objective A, however, through the PDSA cycle review process, this will be closely monitored. With the included option of adding member details for all three (3) Quality of Life questions that are marked as Very or Somewhat, Lakeland Care may be able to determine additional details from the qualitative data.

Health equity considerations incorporated into the tool for Objective A include gathering data on member demographic data, including age, race, ethnicity, language, sex, gender identity (when applicable), and disability status as a valuable tool for quality improvement.

Objective 2: MCO regularly assesses and documents cohort members' community connection interest level, including current participation in community activities.

## 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

The Community Connections Member Interest Inventory is a tool adapted from the National Quality Forum (NQF) Meaningful Activity measures. In addition to modifying the questions to best suit the project needs, the collective MCOs developed an additional question that categorized like activities to provide broad examples to members.

In addition to the assigning cohort members to the TruCare Program (reference #3, Objective B), Lakeland Care’s 2023 revised Care Plan builder implemented in May of 2023 has afforded IDT staff flexibility when creating member-specific goals. Lakeland Care intends on making additional TruCare system changes to the Care Plan builder that will afford IDT staff to delineate whether the service/support is a paid support, natural support, and if the support is related to community connections. When developing reports, Lakeland Care will be able to splice information to determine how community connections are occurring for the cohort members as well as the written barriers noted on the Care Plan.

## how the MCO plans to engage with their members

Lakeland Care’s MAC as well as Tribal Advisory Committees reviewed the Community Connections Member Interest Inventory to provide feedback and input. Both committees felt the inventory was easy to navigate, expansive with options, and would provide data as to barriers as well as who member’s rely on for assistance when engaging in community activities.

Lakeland Care’s MAC was a huge catalyst for significant changes to the Care Plan. MAC members voiced concerns over the length of the previous Care Plan and its readability. Direct feedback from the MAC helped to streamline the Care Plan, create efficiencies while maintaining flexibility for member specific information.

## timeline(s) and detail description(s) of what the new development(s) or modification(s) will involve

Configuration changes for the Community Connections Member Interest Inventory and Care Plan revisions were submitted and anticipated to be available for testing by October 31, 2023, and ready for implementation Q1 2024.

IDT staff will be trained on the Community Connections Member Interest Inventory and how to document member specific community connection goals (including goals, strengths, preferences, barriers, and interventions) during one of the three Community Connections Training Series; the series will be held October, November, and December 2023.

## 

## 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.

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

PDSA cycles will determine if the implementation tools and system changes are effective. Lakeland Care will closely monitor if changes are necessary to the Community Connections Interest Inventory and Care Plan changes implemented for the P4P.

Health equity considerations incorporated into the tool for Objective 2 include gathering data on member demographic data, including age, race, ethnicity, language, sex, gender identity (when applicable), and disability status as a valuable tool for quality improvement.

Lakeland Care Objective B: 80% of cohort members assessed as ‘Interested in developing community connections: Knows desired activity/connection’, ‘Interested in developing community connections: Unsure of desired activity/connection’, or ‘May be interested in developing community connections’, will complete a follow up activity within 90 days from 1/1/2024 to 12/31/2024.

## 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

The TruCare Program will provide task reminders to prompt IDT staff to complete the necessary follow up activities within the timeframe. IDT staff will complete documentation of an activity follow up in Member Case Notes and reflect activity specifics on the MCP. IDT staff will ensure the paper copy of the activity is scanned into the member record.

## how the MCO plans to engage with their members

IDT staff will engage members in dialogue about exploring community connections, civic engagement, etc. more in depth at the time of introducing the Community Connections Interest Inventory (reference slide 36 from the Lakeland Care Community Connections Training Curriculum).

## timeline(s) and detail description(s) of what the new development(s) or modification(s) will involve

Configuration changes request was submitted and anticipated to be available by October 31, 2023, and ready for implementation Q1 2024.

IDT staff will be trained on the required member follow up activities during one of the three Community Connections Training Series; the series will be held October, November, and December 2023.

## 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.

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

Based on member feedback, IDT staff feedback, and other stakeholder feedback as well as data related to utilization, Lakeland Care may explore including either the TUCPM, Head, Heart, and Hands, or the Community Mapping as part of the TruCare system. At this time, simple reports will allow Lakeland Care to monitor the implementation tools and determine future next steps.

Health equity considerations incorporated into the system for Objective B include gathering data on member demographic data, including age, race, ethnicity, language, sex, gender identity (when applicable), and disability status as a valuable tool for quality improvement.

Objective 3: MCOs will collaboratively complete a community readiness activity for at least one county in each of the current Geographic Service Regions (GSR).

## 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

The community readiness activity will be a new development that the collective MCOs will develop with the assistance of the Community Connections Stakeholder Committee. Reference Part 2C: 11 for additional details related to community readiness activities.

## how the MCO plans to engage with their members

MCOs will engage members through the Community Connections Stakeholder Committee as to potential readiness interview questions, potential key respondents within the selected GSR locations, ranking, etc.

## 

## timeline(s) and detail description(s) of what the new development(s) or modification(s) will involve

Community readiness interview questions will be determined within Q2 2024 to allow for at least one quarterly meeting to propose the community readiness activity and to solicit input.

## 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.

Lakeland will be using this tool for the 2024 Specific Incentive Plan. PDSA cycles will determine if the implementation tools (interview questions) and/or if different recipients of the readiness questions are necessary.

Health equity considerations incorporated into the readiness assessment tool for Objective 3 include gathering data on community demographic data, including age, race, ethnicity, language, sex, gender identity (when applicable), and disability status ss a valuable tool for quality improvement. Additional considerations may be included based on Stakeholder Committee review and determination.

Lakeland Care Objective C: Cohort member’s six month level of satisfaction with their community connections involvement will be maintained or increased by 2% in the T2B (Top 2 Boxes); Very Satisfied and Satisfied from the initial assessment from 1/1/2024 to 12/31/2024.

## 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

Lakeland Care will modify the Comprehensive Assessment and Reassessment within the electronic member record system (TruCare) to include the Community Connections Member Interest Inventory. All members in cohort who completed the Interest Inventory and answered the member satisfaction question “Currently, how satisfied are you in participating in activities within the community?” will be included in the objective C.

## how the MCO plans to engage with their members

IDT staff will encourage member participation in all community connections dialogue, activities, etc. and then document the member’s satisfaction with their level of community involvement.

## 

## timeline(s) and detail description(s) of what the new development(s) or modification(s) will involve

Configuration changes request was submitted and anticipated to be available by October 31, 2023, and ready for implementation Q1 2024.

IDT staff will be trained on the required member Interest Inventory during one of the three Community Connections Training Series; the series will be held October, November, and December 2023.

## 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.

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

PDSA cycles will determine if the implementation tools and system changes are effective. Lakeland Care will closely monitor if the system to gather the member satisfaction is effective via the member assessment. Exploring the potential of including additional community connection related survey questions for the Lakeland Care Member Satisfaction Survey will be evaluated during PDSA cycle review.

Health equity considerations incorporated into the tool for Objective C include gathering data on member demographic data, including age, race, ethnicity, language, sex, gender identity (when applicable), and disability status as a valuable tool for quality improvement.

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

The overall aim of the Community Connections P4P is to increase the percentage of members who are active in inclusive community life and civic engagement and to provide the opportunity for members to integrate into their communities and to be socially connected, in accordance with their personal preferences. Through the Strategic Plan, MCOs are committing to collaboratively and consistently implementing best practices intended to lead to increased rates of community connections over the next five years and beyond. Lakeland Care will ensure long-term sustainability by integrating these best practices into their standard operating policies and procedures.

This Initiative will establish a successful process for engaging members in community connections and civic engagements through guided identification assessment activities and establish member-specific goals incorporated into the care plan using best and/or evidence-based techniques and strategies.

Lakeland Care’s key concepts included in achieving sustainability:

1. Adherence to the success of the Model for Improvement by continuing to set measurable and quantifiable goals, developing an agile plan for achieving the goals, determining the timeline for goal completion, and after implementation, conducting after action reviews to determine plan modifications for the next cycle.
2. Lakeland Care values leadership support and commitment as a key to successful change management. Initiatives require establishing a clear vision, communicating the vision with others, and resolving potential barriers and conflicts in carrying out the vision. Lakeland Care’s Leadership team is dedicated towards efforts to promote a successful and sustainable community connections program within Family Care. To maintain this commitment, Lakeland leaders will continue to uphold the Lakeland Values of trust, kindness, and inclusion, maintain project transparency and communication, as well as encouraging critical thinking when problem solving.
3. By having consistent use of process improvement tools and techniques such as the levels of interest being tracked and monitored every six (6) months, Lakeland Care will be able to determine continuous improvement or rapid/next PDSA cycles to help determine further interventions that will propel the membership closer towards the overall aim. It is anticipated that the proposed interventions will become more reliable and sustainable as the project progresses through additional cohorts, thus allowing the tracking and reporting of measurable increases over time. Included in the continuous improvement is systematized review of policies and procedures to ensure an effective process and ongoing evaluation and measurement of goals and activities.
4. Lakeland Care will ensure member feedback and decision making from various member stakeholders throughout the project and beyond the five (5) years. This will include Member Advisory Committee participation and input, member, family and natural support participation and feedback, etc. on tools and resources utilized, identifying challenges, and creating member specific solutions.
5. Lakeland Care will ensure there is intentional communication with members, providers, and stakeholders regarding the Community Connections P4P and success of fully incorporating community connections and civic engagement into Family Care.
6. Lakeland Care will continue to provide regular educational opportunities (trainings, refresher resources, etc) for employees to build their skill set as it relates to community connections, civic engagement, volunteering, motivational interviewing, assessment, care plan building, and care coordination.
7. Lastly, Lakeland Care will evaluate and monitor any changes to financial processes and procedures that are necessary to align with the Community Connections P4P.

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# 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.

Lakeland Care’s individual MCO IDT staff training will be developed and implemented by the Best Practice Team, Specialty Support, and Care Management. All trainings will be added to the LCI organizational Training Log.

Lakeland Care training leaders will be comprised of representatives from Best Practice, Care Management, Specialty Supports, and Quality departments.

1. Stephanie Phillips, Care Management Best Practices Manager: Stephanie is an LCI representative on the MCO Joint Committee - Current Practice Workgroup and Training Workgroup. She leads a team that creates resources and facilitates trainings to support the understanding and application of the Family Care contract as well as the effective use of the electronic member record system. Stephanie will be incorporating information and lessons learned from the recent NCAPPS Leadership Learning Collaborative.
2. Taylor Tamayo, Family Care Program Manager: Taylor is a Family Care Management leader who is deeply involved in the oversight and understanding of IDT staffs’ day-to-day responsibilities and performance in supporting members in their communities. She is an advocate in working with external entities to find solutions to barriers the members experience.
3. Paige Domach, Family Care Program Director: Paige is an LCI representative on the MCO Joint Committee - Current Practice Workgroup and Training Workgroup. Paige leads IDT staff, CM Supervisors, and Program Managers in exceptional delivery of the Family Care Program.
4. Jessica Quam, Care Management Practice Support Director: Jessica is an LCI representative on the MCO Joint Committee - Contract Language workgroup. She leads all LCI Care Management Support Departments, including Community Supports, through a member-centered and solution-focused approach.
5. Jason Berdyck, Specialty Supports Manager: Jason is currently the Specialty Support Manager involved in the oversight of the supports provided to Care Management IDT including Community Supports. He is a certified instructor for the Wisconsin Department of Health Services, Bureau of Assisted Living, Department of Quality Assurance. He has direct training experience in the assisted living and long-term care industry. He has designed educational offerings related to the care of adults with intellectual disabilities including continuing education workshops, webinars, and online courses for licensed and certified adult family homes (AFH), community based residential facilities (CBRF), and residential care apartment complexes (RCAC).
6. Rose White, Community Supports Supervisor: Rose oversees the specialty supports most directly related to community integration, including employment- and housing-related opportunities and supports.
7. Gina Redmann, Prevention & Wellness Program Manager: Gina leads the review of research and creation of resources related to the social determinants of health and their importance and impact on membership.
8. Jen Harrison, Chief Operations Officer: Jen is the MCO Joint Committee Executive Representative. As Executive Sponsor, Jen is 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.
9. Stephanie Bloedorn, Community Supports Manager: Stephanie leads the Community Supports Department which includes Employment, Self Determination and Housing. She has extensive experience in these areas and supports her team with a member centered approach.

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| **Lakeland Care Training Topic** | **Training Method, Length, Type, Documentation** |
| Introduction to Community Connections   * 1. Community Connections Pre-Test   2. Definition of Inclusive Community Life and Civic Engagement      1. Valued social roles;      2. Interaction with other community members when and where the member wants;      3. Explore their interests;      4. Participate in personally meaningful activities;      5. Achieve their authentic goals in the same way as a community member in the; member’s geographic area who is not receiving Medicaid.   3. What is Community Connections – clarifying definition   4. Essential Concepts      1. DHS Framework;      2. Valued social roles;      3. Person-Centered thinking, planning, and practices;      4. Belongingness;      5. Health Equity;      6. Valued social relationships;      7. Community;      8. Community inclusion;      9. Social role valorization;      10. Social connectedness | * Live/Virtual Meeting * ~30 minutes for introduction section * Asynchronous * Virtual Meeting Attendance Report |
| Philosophical Shift   * 1. Making the case for supporting members with disabilities to engage in community connections and civic engagement;   2. Benefits of members engaged in their communities.   3. Supportive Data | * Live/Virtual Meeting * ~20 minutes for philosophical section * Synchronous * Virtual Meeting Attendance Report |
| MCO Collective Vision   1. Brief review of introduction to Community Connections 2. MCO Collective Vision 3. Why Community Connections was chosen as P4P focus area:    * 1. High-level overview of research on national measures;      2. Stakeholder feedback;    1. Overview of the Strengths/Weaknesses/Opportunities/Threats (SWOT) analysis. | * Live/Virtual Meeting * ~20 minutes for MCO Collective Vision section * Synchronous * Virtual Meeting Attendance Report |
| 2024 Community Connections Initiative: Overview of Strategic Plan   * 1. Overview of Community Connections Strategic Plan goals and objectives      1. Expectations of MCOs and IDT staff for 2023 and 2024;      2. Expectations in future years – increasing the number of members involved in community connections will be expected for MCOs to earn incentive dollars;      3. Expectations of MCOs with monitoring and reporting.   2. Define scope of Community Connections Initiative including      1. Eligibility/cohort      2. Stakeholders      3. Resources: Enhancements – to existing practice and tools. | * Live/Virtual Meeting * ~30 minutes for Overview of Strategic Plan section * Synchronous * Virtual Meeting Attendance Report |
| Expectations of IDTs   1. Expectation: Conversation/discussion to determine interest category and what next steps will be implemented with member 2. Navigating the Community Connections Program in TruCare 3. Introduce the Community Connections Interest Inventory categories; providing specific IDT staff guidance for the five (5) current interest levels:    1. Currently involved in community connections: guidance to IDT will focus on maintaining community connections, review of potential barriers and potential interventions to overcome barriers.    2. Interested in developing community connections: knows desired activity/connection: guidance will focus on motivational interviewing techniques to best prepare the member in taking the next step towards action, review of barriers and interventions to overcome barriers and goal setting.    3. Interested in developing community connections: unsure of desired activity/connection: guidance will focus on motivational interviewing techniques to best prepare the member in taking the next step towards identifying activities of interest, review of barriers and interventions to overcome barriers, and goal setting.    4. May be interested in developing community connections: guidance will focus on motivational interviewing techniques to best provide education and encouragement in taking the next step towards identifying activities of interest, review of barriers and interventions to overcome barriers, and goal setting.    5. Not interested in developing community connections: guidance will focus on continued re-approach methods to assist the member (if they choose) to advance to the next interest level. 4. Working with members to identify desired level of community connections 5. Best practices for IDTs prior to conversation/discussion 6. Sharing information or things to think about in advance of conversation/discussion;    1. Expectations for members who also have a legal guardian and/or very involved parents/family.       1. Best practices for IDTs in conducting conversation/discussion 7. Face to face whenever possible is optimal 8. How to introduce the topic & engagement strategies 9. Using technique(s) associated with motivational interviewing model/spirit or other best practices 10. Techniques to determine where person is in relation to wanting to make this change:     1. Use open-ended questions;     2. Use interactive case scenarios for training purposes;     3. Responding to immediate questions and concerns;     4. Strategies to mitigate member risk;     5. Sharing success stories; 11. Addressing why now might be good time for member to pursue community connections or take time to learn more about community connections as an option; 12. Understanding and addressing barriers (transportation, technology, staffing). 13. How to support when member and legal decision maker differ on level of interest of community connections. 14. Working with members to increase level of community connections.     1. Best practices for IDTs. | * Live/Virtual Meeting * ~60-90 minutes for Expectations section * Synchronous * Virtual Meeting Attendance Report * TruCare Community Connections Program |
| Documentation Expectations   1. Community Connections Interest Inventory categories - How to document interest category for member; 2. Determining when community connection goal/outcome is added to the MCP, or existing community connections goal needs to be modified/updated in the MCP:    1. How to write a Community Connections goal that is consistent with the member’s authentic goal; 3. Paid and natural supports needed to support members to achieve community connections goal; 4. Expectations regarding follow up activities:    1. What follow-up activities are available;    2. Determining best activity(ies) for each member;    3. Documenting selection of follow up activities selected;    4. IDT expectations for next steps based on selected activity(ies);    5. How to document progress toward and completion of follow up activity(ies); selected (e.g., community mapping, TUCPM, Gifts of the Heart/Hand/Head activity, etc.)    6. Expectation for next steps after identified follow up activity is completed. 5. Expectations for continued engagement, support and follow as needed for member to retain community connections. 6. Where to find resources and how to submit questions. | * Live/Virtual Meeting * ~45-60 minutes for Expectations section * Synchronous * Virtual Meeting Attendance Report * TruCare Community Connections Program |
| * See Appendix C for the activities IDTs will be trained to engage members, and guardians/legal decision makers as applicable. | |

* **October 2023-** Community Connections Part 1: What is Community Connections and Why is it important.
* **November 2023-** Community Connections Part 2: Prepping for the Community Connections Conversation and Best Practice
* **December 2023-** Community Connections Part 3: Community Connections Documentation Expectations and TruCare
* **December 2023** – Optional Community Connections open Q&A session, 60 mins.
* **December 2023** – Email to all staff promoting engagement.
* **January 2024** – Refresher training at the mandatory Operations Staff Meeting to celebrate formal kick off.
* Ongoing yearly training assessment and refresher.

# References

Bourne, M. L. (2022, February). *Person-Centered Practices: For Governmental Agencies That Oversee Human Services.* Retrieved from ncapps.acl.gov: https://ncapps.acl.gov/docs/Resources/NCAPPS%20SelfAssessment\_Final\_March2022%20-%20508%20Compliant.pdf

Survey Monkey. (2022). *How To Use a Top 2 Box Score in Your Survey Analysis*. Retrieved from Survey Monkey: https://www.surveymonkey.com/mp/top-2-box-scores/

# APPENDIX 1

## Below is an example version of the TUCPM that Lakeland Care will offer as a follow up activity.

**TEMPLE UNIVERSITY COMMUNITY PARTICIPATION MEASURE**

**PARTICIPANT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**QUESTION 1:** I am going to ask you about different activities you might have done **during the past 30 days** without a staff person going with you (i.e., someone from an agency or program you are in who is paid to help you). Please indicate the **number of days** during the **past 30 days** you have participated in each activity outside of your home without a paid staff person going with you **unless it is a personal assistant** or other similar type of support.

**QUESTION 2:** Do you do this activity**, *Enough*, *Not Enough, or Too Much***? (circle the correct response)

* **INTERVIEWER NOTE**:  If respondent has NOT done an activity in the past 30 days, the number of days would be 0. See the Library example below.
* If respondent did NOT want to do the activity in the past 30 days, indicate: “Enough.”
* If respondent wanted to go to the Library, but did the activity 0 times during the past 30 days select: “Not Enough.”

**QUESTION 3:** Is this activity important to you?  (circle the correct response)

**Example:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. How many days during the past 30 days did you do the following activities without a program staff person going with you:** |  | **B. Number of Days**  **(without a staff person)** |  | **C. Do you do this activity?** | | |  | **D. Is this activity important to you?** | |
| **Enough** | **Not Enough** | **Too Much** | **Yes** | **No** |
| 9. Go to a library. | **\_\_ \_0\_**  (# of Days) | 1 | Shape  2 | 3 | Shape  1 | 0 |
| 24. Entertain friends in your home or visit friends in their homes. | **\_\_ \_5\_**  (# of Days) | Shape  1 | 2 | 3 | Shape  1 | 0 |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. How many days during the past 30 days did you do the following activities without a program staff person going with you:** |  | **B. Number of Days**  **(without a staff person)** |  | **C. Do you do this activity?** | | |  | **D. Is this activity important to you?** | |
| **Enough** | **Not Enough** | **Too Much** | **Yes** | **No** |
| 1. Go shopping for pleasure or entertainment (e.g., at a grocery store, convenience store, shopping center, mall, other retail store, flea market, or garage sale.) | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 2. Go to a restaurant or coffee shop. | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 3. Go to a church, synagogue, or place of worship. | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 4. Go to a movie theater. | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 5. Go to a park or recreation center. | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 6. Go to a theater to watch a play, concert, dance, or other similar type of cultural event (not a movie theater). | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 7. Go to a zoo or botanical garden/arboretum. | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 8. Go to a library or museum. | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 9. Go out of the house to watch a sports event (including bowling, tennis, basketball, etc.). | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. How many days during the past 30 days did you do the following activities without a program staff person going with you:** |  | **B. Number of Days**  **(without a staff person)** |  | **C. Do you do this activity?** | | |  | **D. Is this activity important to you?** | |
| **Enough** | **Not Enough** | **Too Much** | **Yes** | **No** |
| 10. Go to a gym, health or exercise club, or pool, for leisure and recreation. | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 11. Engage in an organized sport’s team or activity (baseball, basketball, soccer game) or other organized physical activity (e.g., exercise class) outside the home. | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 12. Play games in-person (e.g., chess, cards, board game) outside of one’s house with friends or family. | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 13. Play games, including online gaming, at your own home where you play with others (they may be physically present in your home or online). | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 14. Go to a barber shop, beauty salon, nail salon, or spa for enjoyment (i.e., you do it because you enjoy it and not because you simply need a haircut). | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 15. Use public transportation (buses, subway, trains). | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 16. Go to a group activity outside your home. For example, go to a book club, knitting group, or other group activity with people who have similar interests as you. | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 17. Work for pay. This could be full- or part-time work. | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 18. Go to school to earn a degree or certificate (for example: GED, adult education, college, vocational or technical school, job training). | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. How many days during the past 30 days did you do the following activities without a program staff person going with you:** |  | **B. Number of Days**  **(without a staff person)** |  | **C. Do you do this activity?** | | |  | **D. Is this activity important to you?** | |
| **Enough** | **Not Enough** | **Too Much** | **Yes** | **No** |
| 19. Take a class for leisure or life skills (for example, classes for cooking, art crafts, ceramics, and photography). |  | **\_\_\_\_ \_\_\_\_**  (# of Days) |  | 1 | 2 | 3 |  | 1 | 0 |
| 20. Participate in volunteer activities (i.e., helping others or an organization without being paid). |  | **\_\_\_ \_\_\_\_**  (# of Days) |  | 1 | 2 | 3 |  | 1 | 0 |
| 21. Get together in the community or attend a formal event with family (for example, a wedding, bar mitzvah). |  | **\_\_\_ \_\_\_\_**  (# of Days) |  | 1 | 2 | 3 |  | 1 | 0 |
| 22. Get together in the community or attend a formal event with  friends (for example, a wedding, bar mitzvah). |  | **\_\_\_ \_\_\_\_**  (# of Days) |  | 1 | 2 | 3 |  | 1 | 0 |
| 23. Entertain family in your home or visit family in their homes. | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 24. Entertain friends in your home or visit friends in their homes. | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |
| 25. Hang out or socialize with people you know from school, work, the neighborhood, or other acquaintances. These would people you DO NOT consider to be close friends. |  | **\_\_\_\_ \_\_\_\_**  (# of Days) |  | 1 | 2 | 3 |  | 1 | 0 |
| 26.  Go to a community fair, block party, community clean-up day, or other community event or activity. |  | **\_\_\_\_ \_\_\_\_**  (# of Days) |  | 1 | 2 | 3 |  | 1 | 0 |
| 27. Attend or engage in civic or political activities or organizations (e.g., neighborhood watch or advocacy groups) or professional associations (e.g., conference or union meeting). | **\_\_\_\_ \_\_\_\_**  (# of Days) | 1 | 2 | 3 | 1 | 0 |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **The following questions asks about your relationship with an intimate partner and you child(ren).** | | | |  |  |  |  |
| 28. Are you currently married or in a domestic partnership/relationship (i.e., not married, but in a committed relationship or living with someone you are in an intimate relationship with)? |  | Yes | No |  |  |  |  |
|  |  |  |  |  |  |  |  |
| 29. If you ARE NOT currently married, in a domestic partnership, or living with an intimate partner (you answered “No” on question 28) please answer these questions… |  | **A. How many days in the last 30 days did you get together with someone you consider to be a boyfriend/girlfriend?** | **B.** **Do you do this activity?** | | | **C.   Is this activity important to you?** | |
| How many days in the last 30 days did you get together with someone you consider to be a boyfriend/girlfriend? |  | **\_\_\_\_ \_\_\_\_**  (# of Days) | Enough | Not Enough | Too Much | Yes | No |
|  | | | | | | | |
| 30. Are you a biological, adoptive, foster, or step parent? |  | Yes | No |  |  |  |  |
| 31. If you DO have children (“Yes” on Question #30), do you live with your child(ren)? |  | Yes | No |  |  |  |  |
|  |  |  |  |  |  |  |  |
| 32. If you have children (“Yes” on Question #30), but do NOT live with them (“No” on Question #30), please answer these questions… |  | **A. How many days in the last 30 days have you gotten together with your child(ren)?** | **B. Do you do this activity?** | | | **C.   Is this activity important to you?** | |
| How many days in the last 30 days have you gotten together with your child(ren)? |  | **\_\_\_\_ \_\_\_\_**  (# of Days) | Enough | Not Enough | Too Much | Yes | No |

# APPENDIX 2

## Example of the PDF fillable My Community Map that Lakeland Care will offer as a follow up activity.

A map of community with many people

Description automatically generated