A Roadmap to Success in LTSS

A compilation of resources to guide organizations through meeting Case Management and Health Plan Standards for LTSS

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SECTION 1: Introduction to NCQA

The National Committee for Quality Assurance (NCQA) has a long history of developing evaluation products and programs to meet identified needs. The release of NCQA's Case Management (CM) for Long Term Services and Supports (LTSS) Accreditation program and the LTSS Distinction module creates an opportunity for community-based organizations (CBO), health plans, case management organizations and managed behavioral healthcare organizations to demonstrate their ability to deliver LTSS and coordinate with other health care and service providers, people and organizations. These accreditation and distinction programs promise to improve outcomes for people with LTSS needs; however, organizations new to LTSS or to NCQA Accreditation may need support to meet the standards.

This roadmap will help organizations understand the accreditation process and standards, and will guide them through the steps of preparing for the accreditation review process. It complements the LTSS standards and provides examples, tools and resources you can use to prepare your organization for the accreditation journey.

The roadmap includes a variety of resources to help organizations consider different ways to meet the standards for LTSS. Many of the tools and examples are taken (in whole or in part) from real organizations. Some examples are composites of a variety of sources; a few are invented to illustrate key points. Nothing contained in this roadmap is intended to be prescriptive—there are many ways to meet a standard. Each resource is an example only, intended to illustrate one way to meet part of a standard. Organizations are free to use the materials contained in this roadmap and to adapt them to fit their circumstances.

SECTION 2: Quick Guide to Getting Started

Icons are used throughout the roadmap to identify and highlight the LTSS standards in Section 4, Resources for Meeting LTSS Requirements and Types of Resources. Tables 1 and 2 below display the icons and a description of each chapter and type of resource.

TABLE 1. Icons to LTSS Standards

ICON	DESCRIPTION
	**Program Description:** Organizations use up-to-date evidence and professional standards to develop their case management programs, and regularly update programs with emerging findings and information.
	**Assessment Process:** Organizations systematically assess the populations they serve and have a process for conducting comprehensive assessments.
	**Person-Centered Care Planning and Monitoring:** Organizations have a process for developing individualized care plans that incorporate personal preferences, prioritized goals and self-management plans, and monitor progress against those plans.
	**Care Transitions:** Organizations have a process for managing transitions, identifying problems that could cause unplanned care transitions and, when possible, preventing unplanned transitions.
	**Measurement and Quality Improvement:** Organizations measure and work to improve participant experience, program effectiveness and active participation rates.
	**Rights and Responsibilities:** Organizations communicate the rights and responsibilities of participants in a case management program.

TABLE 2. Icons for Type Resources

ICON	DESCRIPTION
	**Tools:** Tools include surveys and organizational assessments. They include questions to ask and forms that can be completed and customized to an organization.
	**Examples:** Examples include sample documents that show how organizations demonstrate that they meet standards.
	**Links to Resources:** Resources include websites with useful information or tools related to person-centered care, care transitions or quality improvement.
	**Reports, Toolkits, and Articles:** Reports, toolkits and articles include useful and related materials that are too long, or copyrighted, and could not be included in the roadmap.

SECTION 3: Getting Organized

A. Seek Leadership Support

Preparing for accreditation takes time and effort, and usually requires changes in organizational processes. Often, making changes requires authority and resources. Like most large change efforts, success depends on leadership support. Organization leadership must provide access to key decision makers and resources, while protecting the time required to undertake the change.

Most leaders will expect to see a return on investment. The best way to convince them to invest in accreditation is by demonstrating how it can support business goals such as expanding current revenue streams and securing new contracts. Accreditation also presents an opportunity to enhance business operations and workflows, resulting in more efficient use of staff time and resources. To maintain leadership support, the team should provide regular updates, and should check in before implementing major changes.

B. Form a LTSS Accreditation Preparation Team

Forming a team is recommended to prepare for accreditation. Although there should be one team leader, one person alone cannot prepare an organization for accreditation. Keep in mind that change takes time and planning while the organization prepares for accreditation, developing and implementing new policies and procedures. The LTSS accreditation preparation team should schedule weekly meetings to plan and track progress in a way that builds momentum. As the team begins implementing changes, it is also important to have a plan for keeping the rest of the organization informed and involved, so that changes are coordinated. The team's first activity should be to carefully review the standards and identify who is responsible for activities needed to meet each one.

C. Conduct a Gap Analysis

After the LTSS accreditation preparation team reviews the standards, it can collaborate to assess the organization's current performance. Critical assessment is important and should be based on what the documented evidence proves, not on what the organization plans to do. Many organizations hire outside consultants to help with this phase because they can be objective about the organization's strengths and weaknesses. It is important to understand clearly where the organization currently meets the standards and where change is necessary.

D. Set a Timeline and Prioritize Efforts

Preparing for accreditation can take up to nine months, from preparation through accreditation review. Once the self-assessment and gap analysis have been completed, the team needs to prioritize necessary changes. Although there may be many areas where the organization's current performance does not meet the standards, they cannot all be addressed at once. The team might consider several factors in prioritizing:

- Impact on accreditation (e.g., is it a critical factor, or a high-point standard?).
- Level of effort required to implement change (e.g., staffing, technology, financial resource requirements).
- Alignment and synergy with other organization activities.

Below are examples of timelines for preparing for accreditation. Exhibit 1 displays a high-level timeline for the preparation process, including review meetings, document upload and training time frames. Exhibit 2 shows examples of revisions needed to meet each CM standard. Exhibit 3 is a screenshot of a month-by-month action plan (see Appendix F for a full version of this timeline).

Exhibit 1. Case Management Review Timeline 2016

CM	Staff	Lead	5/9-5/13	5/16-5/20	5/23-5/27	5/30-6/3	6/6-6/10	6/13-6/17	6/20-6/24	6/27-7/1	7/4-7/8	7/11-7/15	7/18-7/22	7/25-7/29	8/1-8/5	8/8-8/12	8/15-8/19	8/22-8/26	8/29-9/2	9/5-9/9	9/12-9/16	9/19-9/23	9/26-9/30
CM 1					Review Mtg 5/26, 9-11am																		
CM 2							Review Mtg 6/9, 3-5pm																
CM 3							Review Mtg 6/9, 3-5pm																
CM 7									Review Mtg 6/24, 1-3pm														
CM 8									Review Mtg 6/20, 12:30-2:30														
CM 9									Review Mtg 6/22, 10am-12pm														
CM 6																		Review Mtg 8/22, 1-3pm					
CM 4																							
CM 5																							
NCQA Survey Training																							
Survey Upload																							

CM	10/3-10/7	10/10-10/14	10/17-10/21	10/24-10/28	10/31-11/4	11/7-11/11	11/14-11/18	11/21-11/25	11/28-12/2	12/5-12/9	12/12-12/16	12/19-12/23	12/26-12/30
CM 1													
CM 2													
CM 3													
CM 7													
CM 8													
CM 9													
CM 6													
CM 4	Review Mtg 10/3, 2-4 pm												
CM 5			Review Mtg 10/18, 1:30-3pm										
NCQA Survey Training											12/15 11am-1pm		
Survey Upload													

Key		Important Dates:	
Revision Timeframe		Online Survey Tool Training	15-Dec-16
Revisions in Progress		Targeted Dates for Document Upload	December 15 - 23, 2016
Planned Document Upload		Survey Upload Deadline	10-Jan-17
Completed		Onsite Survey	27-Feb-17

Exhibit 2. Case Management Review and Revisions

Review Dates	Review Mtg	CM Standard	Recommendations/ Revisions Needed	Score	Notes	Staff involved	Lead	Review Revisions	*Target Completion*	Ready to Submit	Date Loaded into NCQA ISS Tool
5/16/16-5/27/16	*5/24/16*	*CM-1*							*5/27/16*		
5/16/16-5/27/16	*5/24/16*	*CM-2*							*5/27/16*		
5/16/16-5/27/16	*5/24/16*	*CM-3*							*5/27/16*		
5/16/16-5/31/16	*5/27/16*	*CM-7*	**CM7E:** Ensure the organization uses primary sources to verify valid licensure of all staff for whom licensure is required within 90 days of hiring staff, Done **CM7F:** Ensure the organization has policies and procedures that specify the frequency and process for verifying licensure of staff, using primary sources for verification and ensuring that licensure stays current after initial verification **(CM7F 1)**; the frequency and process for performing ongoing monitoring of clinical staff sanctions and complaints **(CM7F 2);** how and under what circumstances it takes action when it identifies clinical staff sanctions, complaints or quality issues **(CM7F 3).** Done – need to do edits for ISS	Element E: .50/1.00 (50%)					*5/27/16*		
05/30/16-07/15/16	*5/27/16*	*CM-9*	**CM9F** The organization provides information to patients about how their health information will be used, in language that is easy to understand. The information includes routine uses and disclosures of patients' PHI **(CM9F 1);** uses and disclosures of the patients' PHI prohibited by law or customer contract **(CM9F 2);** protections the organization has implemented for PHI in all formats **(CM9F 3);** and, the opportunity to receive the information in factors 1-3 in other languages, as applicable **(CM9F 4).** Refresh the policies to be clear and copy someone else's policy. ASSIGN, REVIEW EXISTING, FIND SUPPLEMENT, REFINE INTO A REAL PATIENT EDUCATION DOCUMENT AND GET TRANSLATED	Element B: .66/.83 (80%)					*7/15/16*		

Exhibit 3. Implementation Timeline and Survey Look-Back—Month by Month Plan of Action

Project Activity	Month																								
	1 MY '15	2 JU	3 JUL	4 AU	5 SE	6 OC	7 NO	8 DE	9 JA '16	10 FE	11 MR	12 AP	13 MY	14 JU	15 JUL	16 AU	17 SE	18 OC	19 NO	20 DE '16	21 JA '17	22 FE	23 MA '17	24 AP	25 MY	26 JU
1. Establish NCQA Team Work Plan	X																								
2. Finalize NCQA PI Plan a. Review and Revise	X	X																X	X	X					
3. HS Programs Gap Analysis			X	X																					
4. All-Program Metrics Spreadsheet	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
5. CM 10, 10.1 and 10.2: Drafted, Reviewed, Finalized [ON HOLD AS OF 5-26-2015]		X	X	X	X																				
6. Technology/Applications Evolution Tracking	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
7. Organization-wide QA Plan			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
8. NCQA **Incident Reporting**: process, terminology, tools, training, small starting projects (PHI PIP, KP Projects)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

E. Implement Changes and Re-assess Performance

Once priorities are identified, it is a good time to check back in with leadership and make sure there is agreement. The team can then "divide and conquer," distributing the changes by area of expertise. The team may also benefit from selecting staff to support changes in areas that are not within their usual scope of responsibility, to broaden "outside" perspectives.

The survey tool can serve as an invaluable resource throughout the self-assessment and change process. Prior to submitting the survey tool for review, responses can be entered and documents that support requirements can be uploaded into the tool's document library as changes are made. This allows the team to monitor progress and generate a self-assessed score in real time.

SECTION 4:

Resources for Meeting LTSS Requirements

NCQA's LTSS standards provide a framework for organizations to deliver efficient, effective, person-centered care that meets people's needs, helps people live in their preferred setting and aligns requirements for CBOs with those of states and managed long-term service and support (MLTSS) organizations. The standards offer a roadmap to improvement. Organizations can use the standards to conduct a gap analysis and as a basis for improvement activities, focusing on areas most important to individuals, payers and states.

These standards were developed through a comprehensive review of industry best practices, Stakeholder Advisory Committee discussions, work with a learning collaborative of CBOs and MLTSS organizations and public comment.

The top-level standards are reflected in this document. Complete Standards and Guidelines for health plans, case management organizations and managed behavioral healthcare organizations are available at ncqa.org.

There are three ways resources appear in the body of the roadmap. Short resources are included in full; longer resources appear as screenshots, with the full resource available either in Appendix A–F, or as a clickable link displayed as the resource title.

Note: If a click link does not work, copy and paste it into your browser (links can be found in the Bibliography).

Table 3. LTSS Standards by Accreditation Program

CM-LTSS	LTSS Distinction (HPA/MBHO Accreditation)	LTSS Distinction (CM Accreditation)
LTSS 1: Program Description	LTSS 1A: Program Description	LTSS 1A: Program Description LTSS 1B: Systematic Review of Evidence and Professional Standards LTSS 1C: Program Content Consistent With Evidence and Professional Standards
LTSS 2: Assessment Process	LTSS 1B: Assessment of Health, Functioning and Communication Needs LTSS 1C: Resource Assessments LTSS 1D: Comprehensive Assessment Implementation	LTSS 1D: Assessment of Health, Functioning and Communication Needs LTSS 1E: Resource Assessments LTSS 1F: Comprehensive Assessment Implementation
LTSS 3: Person-Centered Care Planning and Monitoring	LTSS 1E: Person-Centered Assessments LTSS 1F: Person-Centered Care Planning Process LTSS 1G: Implementing the Care Planning Process	LTSS 1G: Person-Centered Assessments LTSS 1H: Person-Centered Care Planning Process LTSS 1I: Implementing the Care Planning Process
LTSS 4: Care Transitions	LTSS 3: Care Transitions	
LTSS 5: Measurement and Quality Improvement	LTSS 2: Measure and Improve Performance	
LTSS 6: Staffing, Training and Verification	LTSS 1I: Qualifications and Assistance for LTSS Providers	LTSS 1K: Qualifications and Assistance for LTSS Providers
LTSS 7: Rights and Responsibilities	LTSS 1H: Critical Incident Management System	LTSS 1J: Critical Incident Management System
LTSS 8: Delegation	LTSS 4: Delegation	LTSS 2: Delegation





A. Program Description

Organizations use up-to-date evidence and professional standards to develop their case management programs, and regularly update programs with emerging findings and information.

Program Description for ABC CARE
The program description for a fictional organization preparing for CM-LTSS accreditation describes eligibility, services provided, evidence and professional standards used in the program, goals and coordination of services. **The full example is available in** Appendix A.

ABC CARE Eligibility

ABC CARE enrolls all individuals who have been screened by the state as eligible for home- and community-based LTSS, and who opt to receive case management of their LTSS from ABC. The state determines eligibility through means testing and through assessment of functional limitations. Under current approved waiver, individuals are eligible for LTSS if they require moderate assistance with two or more activities of daily living (ADL), or if they require moderate assistance with one ADL and limited assistance with three or more ADLs or instrumental activities of daily living. Upon determination of eligibility for services, the state initiates enrollment into the CARE chosen by the individual. ABC CARE completes enrollment of all individuals who select to use our services, and who complete the enrollment process.

ABC CARE Services

ABC provides the following services to individuals enrolled in our [PROGRAM NAME]:

- Person-centered assessment.
- Care planning.
- Case management of HCBS, including meals delivery, personal attendant services, home health aide services, acquisition and maintenance of DME, home-delivered medication, incontinence supplies, health care-related transportation.
- Transition support for enrolled individuals who have a short-term institutional stay (hospital or SNF) while enrolled in the program.
- Referral to housing, congregate dining, non-healthcare transportation, financial assistance and other community resources available, and for which the individual may qualify.

Evidence and Professional Standards

- ABC CARE integrates the following evidence-based assessments into its assessment process:
- Morse Fall Scale—http://www.networkofcare.org/library/Morse%20Fall%20Scale.pdf
- Mini-Cog—http://geriatrics.uthscsa.edu/tools/MINICog.pdf

Partners in Care Community-Based Care Management/MSSP (2017)—Partners in Care Community-Based Care Management (CBCM) Program Description
The program description for an organization preparing for CM-LTSS accreditation provides a program overview and describes eligibility, services provided, program goals and evidence.
The full example is available in Appendix A.

Overview

The objective of community-based care management (CBCM) is to avoid premature placement in nursing facilities while fostering independent living in the community; avoiding inappropriate use of hospital and emergency department care, and maintaining functioning to the extent possible given patients' age and health conditions. Partners in Care Foundation (Partners) has CBCM programs of various levels of intensity and duration for different populations, using custom-designed targeting criteria for each. In general, Partners' programs address self-care, behavioral health, functional, and social issues for adults with chronic physical, cognitive or emotional conditions who are at moderate to high risk for use of facility-based care (hospital, emergency department, nursing facility). Beyond care management itself, typical services which Partners provides patients, through referral or purchase, can include door-through-door assisted transportation (including companion for doctors' visits, if needed), respite care, home modifications to ensure safety and accessibility, emergency utility payments, replacement of furniture & equipment needed to stay safe and independent (including appliances), home-delivered meals, emergency response system, medication management devices and services, supplementary personal assistance, housekeeper or chore service, in-home therapy—in essence, anything required to keep a safe, healthful and secure environment and to keep individuals in their homes at the highest level of functioning, health and independence possible.

Aging & In-Home Services of Northeast Indiana, Inc. (2017) - Case Management Program Description
The program description for an organization preparing for CM-LTSS Accreditation provides a program overview and describes eligibility, services provided, program goals and evidence.
The full example is available in Appendix A.

I. Eligibility Criteria

a. Case Management

- Individuals must meet both financial and Medicaid eligibility requirements
- To be medically eligible for the waiver program, an individual must meet the required "Level of Care." Level of Care is the minimum need an individual must have to be considered eligible for the waiver, and represents the compilation of medical, professional nursing and non-professional nursing-related needs of an individual based on an assessment of the individual's medical needs, physical, mental and cognitive abilities to ensure the health, safety and well-being of the individual. For the Aged and Disabled or the Traumatic Brain Injury Waivers, a person must be deficient in three Activities of Daily Living (ADLs) or have a skilled need.

- The Level of Care is determined by Aging & In-Home Services and the Division of Aging based upon the Inter RAI assessment and physician's recommendation of home and community-based services, through the 450B form. The case manager will submit this form to the client's primary care physician for completion. The waiver case manager will complete an annual Level of Care evaluation for waiver services.

II. Services

The Aging & In-Home Services Case Management department provides person-centered case management to eligible clients. Case Managers work with each client to identify their goals of care and present options and services to the client. The following options are services offered through the funding programs and are available to clients when developing their care plan. The providers of these services are contracted with Aging & In-Home Services, and the services are not provided by Aging & In-Home Services.

County of San Diego Aging and Independence Services (n.d.)—Live Well Care Connections
The appendices to the *Live Well Care Connections* policies and procedures show how an organization can demonstrate the use of evidence and professional standards in its assessments.
The full example is available in Appendix A.

Appendix	Title
Appendix 1	Acutely Vulnerable Adult Outcome Measurement Tool
Appendix 2	ALEX Referral Intake Form
Appendix 3	LWCC Case Management Application/ Informed Consent
Appendix 4	Authorization to Release Records
Appendix 5	Psycho-Social Assessment
Appendix 6	Elder Self- Neglect Assessments (ESNA)
Appendix 7	KATZ Index of Independence in Activities of Daily Living
Appendix 8	LAWTON Instrumental Activities of Daily Living
Appendix 9	Blaylock Risk Assessment Tool
Appendix 10	Stratify Risk Assessment Tool
Appendix 11	Mini-Cog
Appendix 12	Termination Worksheet
Appendix 13	Article XIV
Appendix 14	Notice of Privacy Practices acknowledgement Form
Appendix 15	Privacy Incident Report
Appendix 16	Privacy Complaint Filing Form
Appendix 17	Authorization to Use or Disclose Protected Health Information
Appendix 18	Customer Satisfaction Survey
Appendix 19	Care Plan
Appendix 20	Civil Rights/Interpreters
Appendix 21	Language Needs
Appendix 22	Contact Letter
Appendix 23	Critical Incident Management

Review of Evidence and Professional Standards for NCQAHealth
The example exhibits how a fictional organization can provide materials from a committee meeting to demonstrate its review of program content, consistent with evidence and professional standards.
The full example is available in Appendix A.

Supplemental Material 1. Program and Policy Review Committee Meeting Minutes

Meeting:	**Program and Policy Review Committee Meeting**
Date	**January 3, 2017**
Attending:	**John Johnson, MHA; Mary Jones, MSN, RN; Jim James, MSW; Jessica Gimenez, PhD; Barry Smith, MBA, MPH**
Minutes Organizer:	**John Smith**

Agenda Item: Program Content and Clinical Guidelines Review	**Discussion**	**Decision**
Current Program Content and Clinical Guidelines	The Committee reviewed the Long-Term Case Management Program (LTCMP) content and clinical guidelines for alignment with the most current evidence available. There was general agreement that the program and guidelines are up-to-date with the exception of those surrounding nutrition, which was suggested for removal. One member disagreed with this, stating the current clinical evidence about the importance of nutrition education in frail elderly points to the maintenance of the guidelines. The member suggested updating the guidelines to better fit the target population's needs.	The Committee agreed to maintain the nutrition guidelines provided updates are made by NCQAHealth.
Agenda Item: Educational Materials Review	**Discussion**	**Decision**
Materials for Participant Education	The Committee reviewed the educational materials made available to individuals in the LTCMP for their alignment with current evidence and professional standards in condition management and understanding their health risks. The Committee found the materials were within current practice and professional standards. Given this finding, the Committee did not suggest updates to be made.	No updates to be made to educational materials.

B. Assessment Process

Organizations systematically assess the populations they serve and have a process for conducting comprehensive assessments.

Population Assessment

This population assessment for a fictional organization preparing for CM-LTSS accreditation describes the service area and the characteristics and needs of its enrolled population.

Our Service Area

Franklin County Senior Services (FCSS) has been providing services for elders of Franklin County and the North Quabbin region for 39 years. It is both an Aging Services Access Point and an Area Agency on Aging, providing advocacy, planning, information and referral, case management, direct services and sub-granted services. FCSS plans for and operates services in 30 towns and for a 60+ population of 19,602 (2010 Census), in the most rural and one of the poorest areas of Massachusetts.

According to the ACS census surveys for 2007-2011, mean Social Security income in Franklin County is $15,750 compared to $16,213 for the U.S. Mean retirement income in Franklin County from the same source, was $18,814 compared to $23,490 for the U.S. and $23,351 in MA. Seven of the towns in our service areas had mean retirement income under $15,000 with the lowest at $13,814. This coincides with the estimate of percentage below poverty in the general population of Franklin County to be 11.9%, compared to 10.7% in MA. The percent of Franklin County households with cash public assistance or SNAP food stamp benefits was 11.8%, compared to 10.3% in the state.

Our service area differs in a number of other ways from the state and the country. Franklin County has a greater percentage of its population that is older and has less racial and Hispanic/Latino diversity than the state or the country. Franklin County has 22.1% of its population 60+ years of age, compared to 19.2% in MA and 18.2% in the U.S. Franklin County has a population that is 96.8% White Alone and Non-Hispanic/Latino, compared to 76.9% for MA and 64.2% for the U.S. In Franklin County 42% of the elder population live alone, compared to 40.5% for the U.S.

FCSS Clients

In 2015, our clients mirrored the service area in terms of income and racial and ethnic make-up, with mean Social Security income of $12,800 (13% below poverty) and 95% of contacts to White Alone and Non-Hispanic/Latino. However, because we serve older adults, our clients are considerably older than the service area average. 99% are native English speakers.

<65	65-74	75-84	>85
8%	28%	37%	27%

In addition to the above demographic profile, our clients have the following needs:

- 86% need assistance with 1 or more ADLs.
- 64% need assistance with 2 or more ADLs, and are nursing home eligible.
- 98% need assistance with at least 1 IADL.
- 99% wear corrective lenses at least part of the time.
- 10% are blind.
- 35% are hearing impaired or use hearing aids.
- 22% have been diagnosed with dementia or some cognitive impairment.
- 18% have depression.
- 20% have alcohol or substance use dependency.

SPD HRA Four Quadrant Breakdown

LA Care uses this brief health risk assessment to identify clients at risk of a transition. See also section D. Care Transitions. **The full tool is available in** Appendix B.

Social Determinants	Medical Conditions
1. Doesn't understand their medical condition(17) *How hard is it for you to understand information about your condition, medicines, or doctor's instructions?* □ Not hard □ Somewhat hard □ Hard 2. Have problems paying utilities (12) *Do you have problems paying your utilities?* □ Utilities (gas, electric, water) □ Rent/mortgage □ Telephone □ None 3. Place of residence (9) *Where do you live?* □ Home with a family member □ Home without a family member □ Friend or family home □ Assisted living home □ Board and care □ Treatment center □ Skilled nursing facility □ Long term acuity care facility □ Homeless □ About to become homeless □ Other 4. Plans to change where they live or who they live with (11) *Do you plan to change where you live or who you live with in the next 6 months?* □ Yes □ No 5. Need help answering these questions (1) *Do you need someone to help you answer these questions?* □ Caregiver □ Legal Guardian □ Family/friend □ No	1. Ability to get an appointment with their doctor in a timely manner in the past 6 months(14) *In the last 6 months how often did you get an appointment at your doctor's office as soon as you needed it?* □ Always □ Sometimes □ Rarely □ Never 2. Have been seen in ED, hospital, urgent care, BH, LTC in last 3 months (16) *In the last 3 months, have you been a patient in or been seen in one of the of the following?* □ Hospital □ Emergency Room □ Urgent Care □ Rehab □ Nursing Home □ Long term acute care facility □ Behavioral/mental health clinic/hospital □ None 3. Miss taking their meds 2 or more times a week (20) *Do you miss taking your medicines 2 or more times a week?* □ Forget to fill □ Forget to take □ Can't get them □ Side effects □ Hard to take/swallow 4. Take any over the counter meds or prescription meds (19) *Do you take any over the counter or prescription medicines?* □ Yes, 5 or less □ Yes, 6 or more □ No 5. How they rate their health (21) *Select the word that best describes your health?* □ Good □ Fair □ Poor

Health, Function and Communication Assessment Questions

The assessment questions below are drawn from multiple assessment tools and show alternative approaches to assessing various aspects of health, functioning and needs. Questions are organized by category. Some categories are divided into subcategories (illustrated by a solid black horizontal line between groups of questions). Some sections have groups of alternative questions (illustrated by a dotted horizontal black line between groups of questions). **See the** Bibliography **for a list of references**.

Category	Assessment Questions
Health status, including condition-specific issues	**Health Status Questions** In the last 3 months, have you been a patient in or been seen in one of the of the following? • Hospital. • Emergency Room. • Urgent Care. • Rehab. • Nursing Home. • Long term acute care facility. • Behavioral/mental health clinic/hospital. • None.
	Condition-specific Issue Questions Problems currently receiving treatment for: [Check all that apply] *If Yes, assess need for intervention/referral • Diarrhea. • Constipation (no BM 3days). • Loss of appetite. • Urinary frequency / urgency 3x/nightly. • Fever. • Vomiting. • Edema. • Dizziness. • Chest pain. • SOB. • Pain (Type, Location, Pattern, Quality descriptive, Treatment).

Category	Assessment Questions
Clinical history, including medications	**Clinical History Questions** Do you have a history of the following health conditions? [Check all that apply] For each: Note dose, route, frequency and prescriber. • Hypertension (high blood pressure) • Heart disease/Angina • Thyroid trouble • Stroke • Parkinson's disease • Cancer • Vision loss • Hearing loss • Chronic pain/Arthritis • Bad nerves/Anxiety • Diabetes • COPD/Asthma • Kidney Disease • GI problems • Anemia/blood problems • Spinal injury • Transplants • Cancer • Serious trauma • AIDS • Multiple chronic illnesses • Chronic illnesses that result in high utilization • Problems currently receiving treatment for? • Are you currently seeing a Psychiatrist or Psychologist? • Mental health problems currently being treated for? • What medications do you take?
	Medication Questions Is medication education provided? **Group 1** Do you ever forget to take your medicine? [Yes/No] Sometimes do you forget to refill your prescription medicine on time? [Yes/No] When you feel better do you sometimes stop taking your medicine? [Yes/No] Sometimes if you feel worse when you take your medicine, do you stop taking it? [Yes/No] Do you know the long-term benefit of taking your medicine as told to you by your doctor or pharmacist? [Yes/No]

Category	Assessment Questions
Clinical history, including medications	**Group 2** Do you miss taking your medicines 2 or more times a week? • Forget to fill. • Forget to take. • Can't get them. • Side effects. • Hard to take/swallow. Do you take any over the counter or prescription medicines? • Yes, 5 or less. • Yes, 6 or more. • No.
	Group 3 How often do you forget to take your medications? How often do you forget to refill prescriptions on time? Do you skip medications? [Yes/No] [If yes] What medications do you skip? How often do you skip medications? Do you need assistance administering medications?
Activities of daily living, including use of supports	**Activities of Daily Living Questions** Does member require assistance with ADL's [Yes/No] with: • Toileting. • Eating. • Mobility/Walk. • Transfers. • Bathing. • Dress/Groom.
	Do you need help getting to places beyond walking distance? [Check all that apply]: • Help with bathing. • Help with grooming. • Help with toileting.

Category	Assessment Questions
Activities of daily living, including use of supports	**Use of Support Questions** Do you have help with daily activities such as taking a bath/shower, grooming, etc.? [Yes/No/Not Applicable] Does member use assistive device for ambulation? [Yes/No]; If Yes, note assistive device used. Amount of assistance required for ambulation. [Free text] What is your living situation? What type of residence do you live in? Are steps needed to access any area of your home? Who is your caregiver? What kind of assistive device do you use?
Instrumental activities of daily living, including use of supports	**Instrumental Activities of Daily Living Questions** Do you need any changes to your home to assist you? Examples may be wheelchair ramp, grab bars in bathroom or other modifications [Yes/No] Does member require assistance with: [Check all that apply]: • Home Skills • Cooking • Shop/Grocery Shop/Errands • Drive/Transport • Telephone • Money Management • Laundry
	Use of Support Questions Do you have help making food, eating, or getting food? [Yes/No/Not Applicable] Do you have help for transportation, paying bills, writing checks, or doing home chores? [Yes/No/Not Applicable]

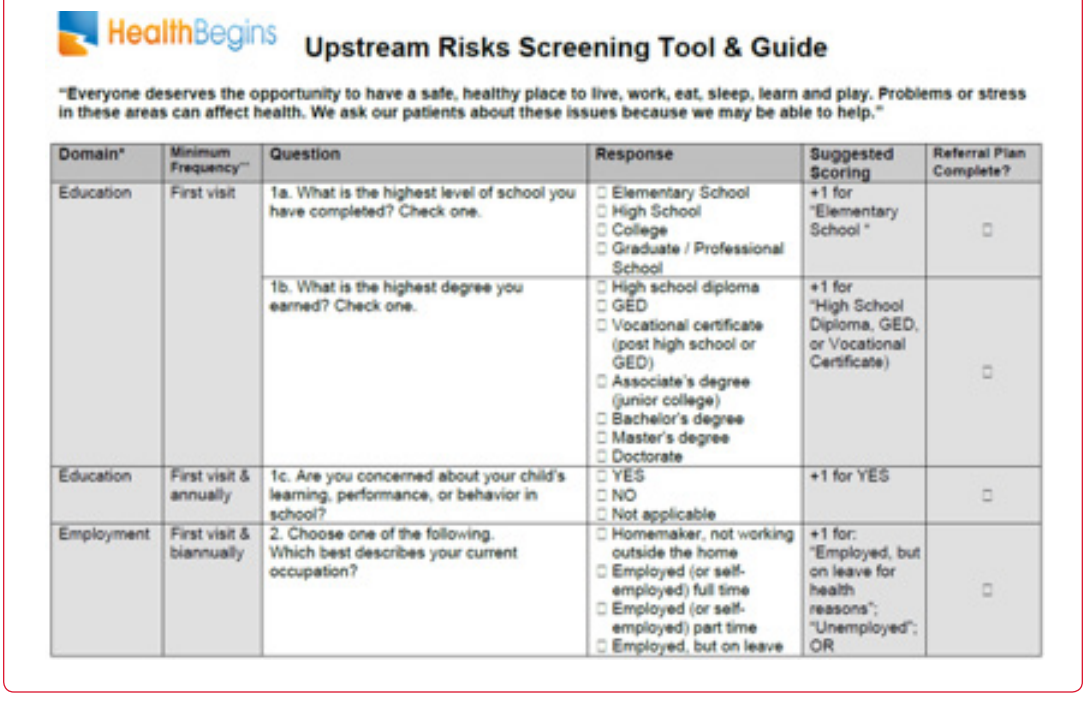
Category	Assessment Questions
Behavioral health status	Does the member have a Mental Health Diagnosis determined by a physician? [Yes/No] [If yes] List diagnosis: Free text Are you currently seeing a Psychiatrist or Psychologist? Mental health problems currently being treated for? [Check all that apply]: • Anxiety. • Combative, Abusive, Hostile Behavior. • Depression. • Delusions/Hallucinations. • Wandering. • Paranoid Thinking/Suspiciousness. • Suicidal. • Alzheimer's Disease/Other related Dementias. • Resists Care. • Other (Grief/Substance Abuse).
Cognitive functioning	**Group 1** Does the member have the ability to do the following [Yes/No]: • Communicate. • Understand Instructions. • Process Information. Additional Information: Free Text
	Group 2 Can you tell me what the current year is? Can you tell me who the current president is? Instruct the patient to listen carefully and repeat: • APPLE WATCH PENNY • MANZANA RELOJ PESETA Administer the Clock Drawing Test Ask the patient to repeat the three words given previously Score: 0 Positive for cognitive impairment 1-2 Abnormal CDT then positive for cognitive Impairment 1-2 Normal CDT then negative for cognitive impairment 3 Negative screen for dementia (no need to score CDT)

Category	Assessment Questions
Social determinants of health	How hard is it for you to understand information about your condition, medicines, or doctor's instructions? • Not hard. • Somewhat hard. • Hard. Do you have problems paying your utilities? [Check all that apply] • Utilities (gas, electric, water) • Rent/mortgage. • Telephone. • None. Is member homeless? [Yes/No] Where do you live? [Check all that apply] • Home with a family member. • Home without a family member. • Friend or family home. • Assisted living home. • Board and care. • Treatment center. • Skilled nursing facility. • Long term acuity care facility. • Homeless. • About to become homeless. • Other. Do you plan to change where you live or who you live within the next 6 months? [Yes/No] Do you need someone to help you answer these questions? • Caregiver. • Legal Guardian. • Family/friend. • No.
Social functioning	Do you have family or friends you can call for help? [Yes/No] How often do you get together with family or friends socially? Do you belong to a church or social group? [Yes/No] Do you feel good spending time with acquaintances, friends, and families? [Yes/No] Are you able to express frustration, concern, anger to family or friends? [Yes/No] Do you participate in social, religious, occupational, or preferred activities? [Yes/No] How long do you spend time alone?

Category	Assessment Questions
Health beliefs and behaviors	**Health Belief Questions** What do you think has caused your illness? How do your symptoms affect your life? What worries you most about your symptoms? What kind of treatment do you want or do you think would work?
	Health Behavior Questions Do you smoke or use tobacco products? [Yes/ No] Do you drink? [Yes/No] If yes, how much per day? Do you use drugs not prescribed by a doctor? [Yes/No] If yes, [Free Text] Do you exercise? [Yes/No] If yes, how many days a week? Minutes a day? Moderate or vigorous exercise?
Cultural and linguistic needs, preferences or limitations	**Cultural Needs, Preferences, Limitations Questions** Family traditions regarding hospice, illness? [Yes/No] with Free Text Are there any health care treatments that are religiously not allowed? [Yes/No] with Free Text Does the member have any cultural barriers that impact the care plan? [Yes/No]
	Linguistic Needs, Preferences, Limitations Questions What is member's preferred language? [Free Text] Does the member have any linguistic barriers that impact the care plan? [Yes/No]
Visual and hearing needs, preferences or limitations	Does the member have any visual limitations? [Yes/No] [If yes] List visual needs/Limitations [Free Text] Does member have a preferred method of communication? [Yes/No] with Free Text Does member have communication decline since last assessment? [Yes/No] with Free Text Does member have any hearing limitations? [Yes/No] with Free Text Does member have any problems with expressing themselves (e.g. problem expressing ideas, trouble in completing a sentence or finding words)? [Yes/No] with Free Text Does member have comprehension issues? [Yes/No, Check all that apply] with Free Text • Problem understanding a conversation • Omits some or part of the message • Still able to understand most of the conversation

Category	Assessment Questions
Physical environment for risk	Does member have issues with environmental risk factors? [Yes/No, Check all that apply] • Loose rugs • Electrical cords • Cluttered house • Unclean house • Unsafe stairs • Other • Inadequate kitchen facilities • Inadequate bathroom facilities • Inadequate heating • Inadequate cooling • Phone accessibility • Weapons • Pets

Manchanda, Rishi and Gottlieb, Laura, HealthBegins (2015)—Upstream Risks Screening Tool & Guide
This assessment tool addresses 14 domains of social risks, including education, employment, social connection, physical activity, stress, housing and transportation. **The full tool is available in** Appendix B.



HealthBegins

Upstream Risks Screening Tool & Guide

"Everyone deserves the opportunity to have a safe, healthy place to live, work, eat, sleep, learn and play. Problems or stress in these areas can affect health. We ask our patients about these issues because we may be able to help."

Domain*	Minimum Frequency**	Question	Response	Suggested Scoring	Referral Plan Complete?
Education	First visit	1a. What is the highest level of school you have completed? Check one.	☐ Elementary School ☐ High School ☐ College ☐ Graduate / Professional School	+1 for "Elementary School "	☐
		1b. What is the highest degree you earned? Check one.	☐ High school diploma ☐ GED ☐ Vocational certificate (post high school or GED) ☐ Associate's degree (junior college) ☐ Bachelor's degree ☐ Master's degree ☐ Doctorate	+1 for "High School Diploma, GED, or Vocational Certificate)	☐
Education	First visit & annually	1c. Are you concerned about your child's learning, performance, or behavior in school?	☐ YES ☐ NO ☐ Not applicable	+1 for YES	☐
Employment	First visit & biannually	2. Choose one of the following. Which best describes your current occupation?	☐ Homemaker, not working outside the home ☐ Employed (or self-employed) full time ☐ Employed (or self-employed) part time ☐ Employed, but on leave	+1 for: "Employed, but on leave for health reasons"; "Unemployed"; OR	☐

C. Person-Centered Care Planning and Monitoring

Organizations have a process for developing individualized care plans that incorporate personal preferences, prioritized goals and self-management plans, and monitor progress against those plans.

Development of a self-management plan

People with chronic conditions need support, as well as information, to become effective managers of their own health. To successfully manage, people need:

- Basic information about their condition
- Understanding of and assistance with self-management skill building
- Ongoing support from members of the care team, family, friends, and community

It is important to be sensitive to the role that families, caregivers, and communities play in different cultures. Better outcomes are achieved through use of evidence-based techniques that emphasize client activation or empowerment, collaborative goal setting, and problem-solving skills. The team can use standardized assessments of patient self-management needs and activities to enhance its ability to support clients. These assessments include questions about self-management knowledge, skills, confidence, supports, and barriers.

Much of the self-management literature comes from research on helping patients with chronic disease, such as asthma and COPD. However, there are many situations in which clients with functional limitations can also benefit from self-management. People who experience pain, anxiety, depression, social isolation, people at risk of acute illness or transition and people whose functional limitations can be reversed, arrested or slowed, can all benefit by developing self-management skills and implementing self-management plans.

Self-management requires readiness, or "activation." Clients must be ready to take responsibility for their own role in managing their condition. This requires their understanding their condition, skills (such as recognizing risks or signs of deterioration, taking medicines properly or practicing exercises), and motivation to participate in managing their condition.

Care managers can help by providing information, or access to information about the condition, and understanding clients' readiness to participate. Understanding a client's health beliefs and readiness to change, and using motivational interviewing, are all ways a care manager can determine how to support a client in self-management. Below is a sampling of the many evidence-based tools available to assess readiness to change or to participate in self-management.

Qualis Health, The Commonwealth Fund, MacColl Center for Health Care Innovation at the Group Health Research Institute (n.d.)—Patient-Centered Interactions

These questions are effective for eliciting the individual's perspective, understanding and view of their illness. See also section B. Assessment Process. **The full tool is available at the link above.**

I. Exploring the meaning of Illness
The patient's perspective: • What do you think has caused your illness? • How do your symptoms affect your life? • What worries you most about your symptoms? • What kind of treatment do you want or do you think would work?
Illness behavior: • Have you seen any other doctors for this problem? • Have you tried any home remedies or non-medical treatments for this problem? • What seems to make your symptoms better? • What makes them worse? • Who advises you about your health?
The patient's agenda: • How can I be of help to you? • What is the most important thing you want to accomplish today?

JH Hibbard, ER Mahoney, J Stockard, M Tusler (2005)—Development and Testing of a Short Form of the Patient Activation Measure

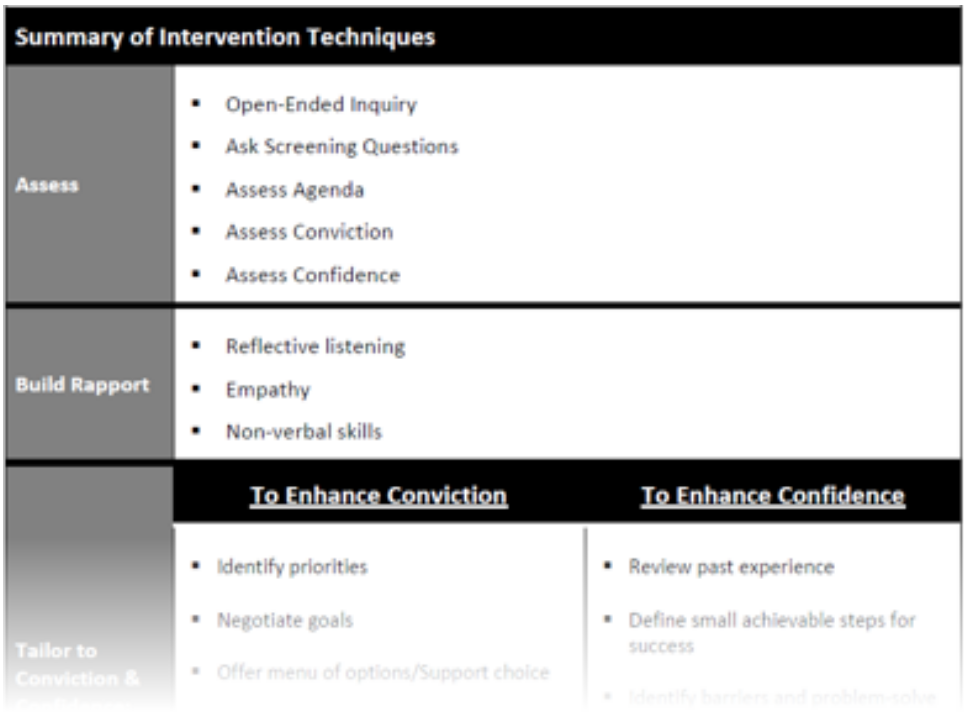
The Patient Activation Measure (PAM) is a 22-item tool to assess knowledge, skill and confidence for self-management. The analysis in the source article finds that the shortened, 13-item tool, displayed below, is both reliable and valid. **The full article is available at the link above.**

1. When all is said and done, I am the person who is responsible for managing my health condition
2. Taking an active role in my own health care is the most important factor in determining my health and ability to function
3. I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition
4. I know what each of my prescribed medications do
5. I am confident that I can tell when I need to go get medical care and when I can handle a health problem myself
6. I am confident I can tell my health care provider concerns I have even when he or she does not ask
7. I am confident that I can follow through on medical treatments I need to do at home
8. I understand the nature and causes of my health condition(s)
9. I know the different medical treatment options available for my health condition
10. I have been able to maintain the lifestyle changes for my health that I have made
11. I know how to prevent further problems with my health condition
12. I am confident I can figure out solutions when new situations or problems arise with my health condition
13. I am confident that I can maintain lifestyle changes like diet and exercise even during times of stress

Institute for Healthcare Communication, Inc. (2011)—Choices & Changes: Communication Tools, Techniques & Strategies: Summary

This eight-page guide is tailored to help providers build and strengthen their person-centered communications. The guide includes the following sections: "Assess—Ask Before You Tell," "Build Rapport" and "Tailor the Method to Match the Patient's Conviction and Confidence: Agree on Goals and Assist."

The full tool is available in Appendix C**.**



Summary of Intervention Techniques		
Assess	• Open-Ended Inquiry • Ask Screening Questions • Assess Agenda • Assess Conviction • Assess Confidence	
Build Rapport	• Reflective listening • Empathy • Non-verbal skills	
Tailor to Conviction &	To Enhance Conviction	To Enhance Confidence
	• Identify priorities • Negotiate goals • Offer menu of options/Support choice	• Review past experience • Define small achievable steps for success • Identify barriers and problem-solve

Richard Wanlass & Debra Fishman, UC Davis Medical Center (n.d.)—Self-Management Action Plan
This Self-Management Action Plan template can be used to develop a self-management plan.

Self-Management Action Plan

One way I want to better manage my health is (examples: walk, stretch, do a relaxation exercise, take medications as prescribed):

_____

I will focus on this for the next _____ (# days, weeks).

When I will do it (examples: every day after work, Mon/Wed/Fri mornings):

_____

Where I will do it (examples: at the gym, in my neighborhood, at physical therapy):

_____

What might get in the way of following through (examples: I may have other things to do, it might rain):

_____

What I will do about it (examples: pick another day, go to the gym, get rain gear):

_____

How successful do I think I will be with my plan?

0% Successful — 50% Successful — 100% Successful

If I rated my chance for success less than 80%, what improvements can I make to my plan to increase my rating?

Maxwell, Hibberd, Pratt, Peek and Baird (2015)— Patient Centred Assessment Method (PCAM)
The *Patient Centred Assessment Method (PCAM)* assessment can be used to assess readiness to participate in self-management. **The full tool can be accessed at the link above.**

Health Literacy and Communication

1.	How well does the client **now understand** their health and well-being (symptoms, signs or risk factors) and what they need to do to manage their health?			
	Reasonable to good understanding and already engages in managing health or is willing to undertake better management	Reasonable to good understanding but do not feel able to engage with advice at this time	Little understanding which impacts on their ability to undertake better management	Poor understanding with significant impact on ability to manage health
2.	How well do you think your client can **engage** in healthcare discussions? (Barriers include language, deafness, aphasia, alcohol or drug problems, learning difficulties, concentration)			
	Clear and open communication, no identified barriers	Adequate communication, with or without minor barriers	Some difficulties in communication with or without moderate barriers	Serious difficulties in communication, with severe barriers

Service Coordination

1.	Do **other services** need to be involved to help this client?			
	Other care/services not required at this time	Other care/services in place and adequate	Other care/services in place but not sufficient	Other care/services not in place and required
2.	Are current services involved with this client **well-coordinated**? (Include coordination with other services you are now recommending)			
	All required care/services in place and well coordinated	Required care/services in place and adequately coordinated	Required care/services in place with some coordination barriers	Required care/services missing and/or fragmented
	Routine Care	**Active monitoring**	**Plan Action**	**Act Now**

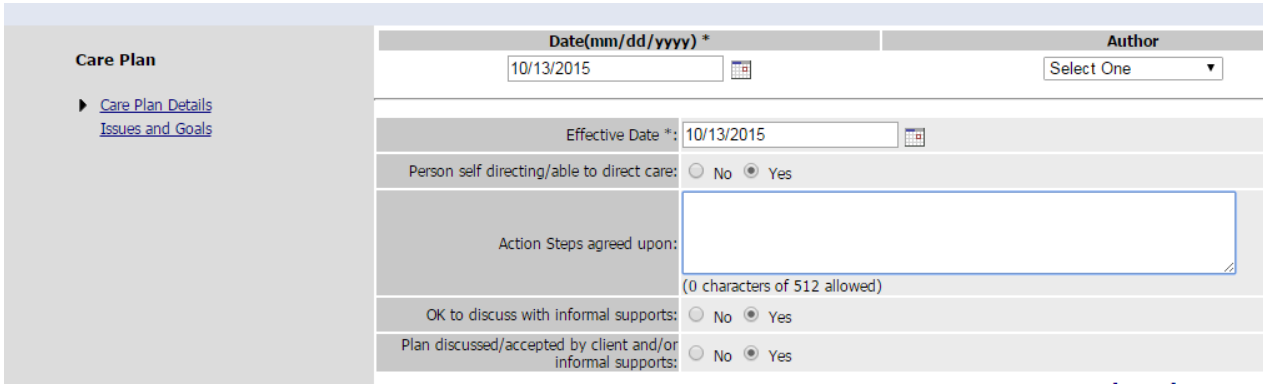
Erie County Department of Senior Services (2016)—Person-Centered Care Plan Policy and Procedure
This policy and procedure for an organization preparing for CM-LTSS accreditation shows how an organization can demonstrate its process for a person-centered assessment and care planning.
The full example is available in Appendix C**.**

Policy:

Case managed clients and/or home delivered meal clients must have a personalized care plan with stated goals. Goals in the care plan may address the client's lifestyle, health, physical function(s), social function(s), etc. Goals must be prioritized and clearly documented. Case Managers will assess for barriers to goal completion. Case Managers will document that barriers were assessed for, even if no barriers are identified. Examples of barriers can include: the client's understanding of his/her condition, financial limitations or transportation limitations. Case Managers and their clients will develop a follow up schedule of at least, but not limited to, the service monitoring schedule to track goal progress. For example, Ms. Smith receives EISEP home care and Home Delivered Meals. Ms. Smith would like to learn a new language. The Case Manager would check in with Ms. Smith at least bi-monthly to see how Ms. Smith is progressing on her goal of learning a new language. The Case Manager provides linkage and support, as needed, through the goal process. Referrals made by the Case Manager must be clearly documented in the Care Plan, Case Notes and the Community Referrals screen in PeerPlace.

Procedure:

All case managed clients and/or home delivered meal clients will have a person-centered care plan completed in PeerPlace. The person-centered care plan will be documented in the Care Plan section, Issues and Goals section (if more space is needed), and in the Case Notes.



National Committee for Quality Assurance (n.d.)—
Goals to Care: How to Keep the Person in "Person-Centered"
This report is intended for those who provide care management services and includes tips and tricks for coordinating goal-based care, illustrated with examples from organizations experienced in providing person-centered care to individuals with complex needs.
The full report is available at the link above.

initiating goal discussions, care managers must acknowledge individuals as experts in their own lives and help them articulate what is important to them. Care managers may use information from assessments to prompt for goals. They can also help people prioritize their goals by putting "first things first" and breaking long-term goals into smaller, attainable action steps.

Tips & Tricks to Elicit Goals

- Before the conversation:
  - Understand the individual's history
  - Understand the individual's current circumstances
- Establish a relationship:
  - Encourage the individual to talk
  - Establish trust by demonstrating interest
  - Learn the individual's capabilities and strengths
  - Tailor the discussion to the individual
- Initiate goal discussion:
  - Acknowledge the individual as the expert
  - Elicit interests
  - Ask the individual about goals and needs
  - Help the individual articulate what's important
  - Listen for readiness to change
  - Suggest goals or preliminary steps
  - Use information from assessments
- Articulate the goals:
  - Confirm understanding: "Did I get this right?"

Step 2: Negotiate Goals

At times, the desires or priorities of the individual may not be immediately attainable or they may differ from those of family, caregivers, providers or care managers. The care manager can help the individual break down a long-term goal into smaller goals that help the individual progress toward their long-term goal, identify and suggest a complementary or supportive goal or help prioritize goals by importance or feasibility. A care manager who is respectful and accepts the individual's goal without judgment can make suggestions that the individual will likely experience as supportive and person-centered.

When the individual's priorities diverge from best clinical practices, preferences or "comfort" of family and caregivers, the care manager must consider and respect the individual's preferences. In these circumstances, with the individual's permission, the care manager can facilitate conversations with the others involved in the individual's care about the individual's goals. When an individual's goals or priorities conflict with clinical recommendations, the care manager can ensure that the individual is fully informed about the options available and the consequences of their choices. In all cases, the care manager and the individual must work toward agreement on a shared goal and a plan to attain it. A shared goal may address a way for the individual's preferences to be supported rather than pursuing treatment for their disease.

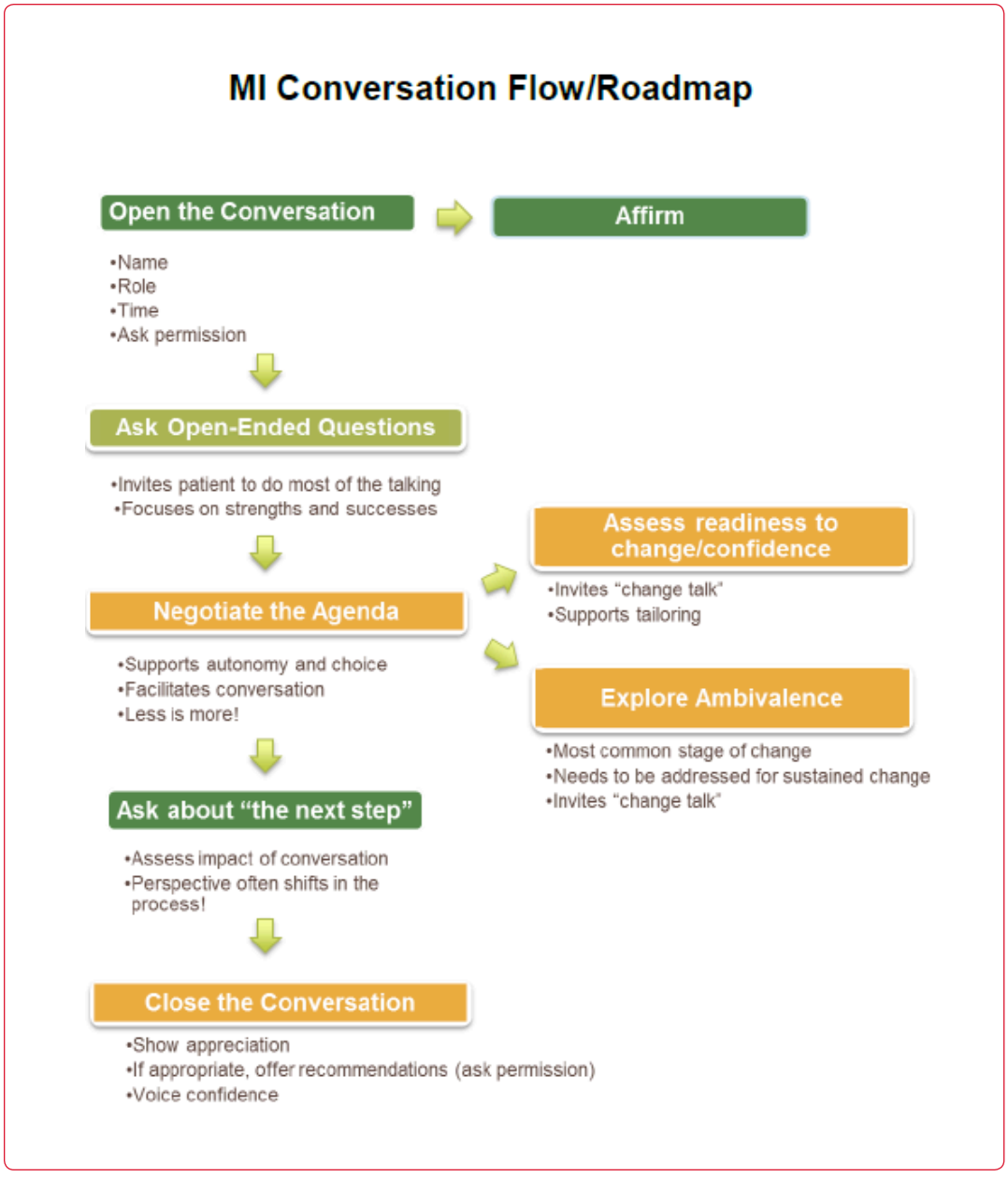
Tips & Tricks to Negotiate Goals

- Break long-term goals into steps
- Prioritize by importance, put "first things first"
- Identify a complementary or supportive goal to the primary goal
- Respect the individual's preferences
- Defer to the goal stated by the individual when there is unresolvable conflict (with the family or the organization)
- Continue to educate and encourage goals that have the potential for positive health and quality-of-life outcomes

"If they do not have a legal guardian, we respect their choices and support them as requested. Sometimes it's not nice, but then we provide the family education that people are allowed to make both good and bad decisions."

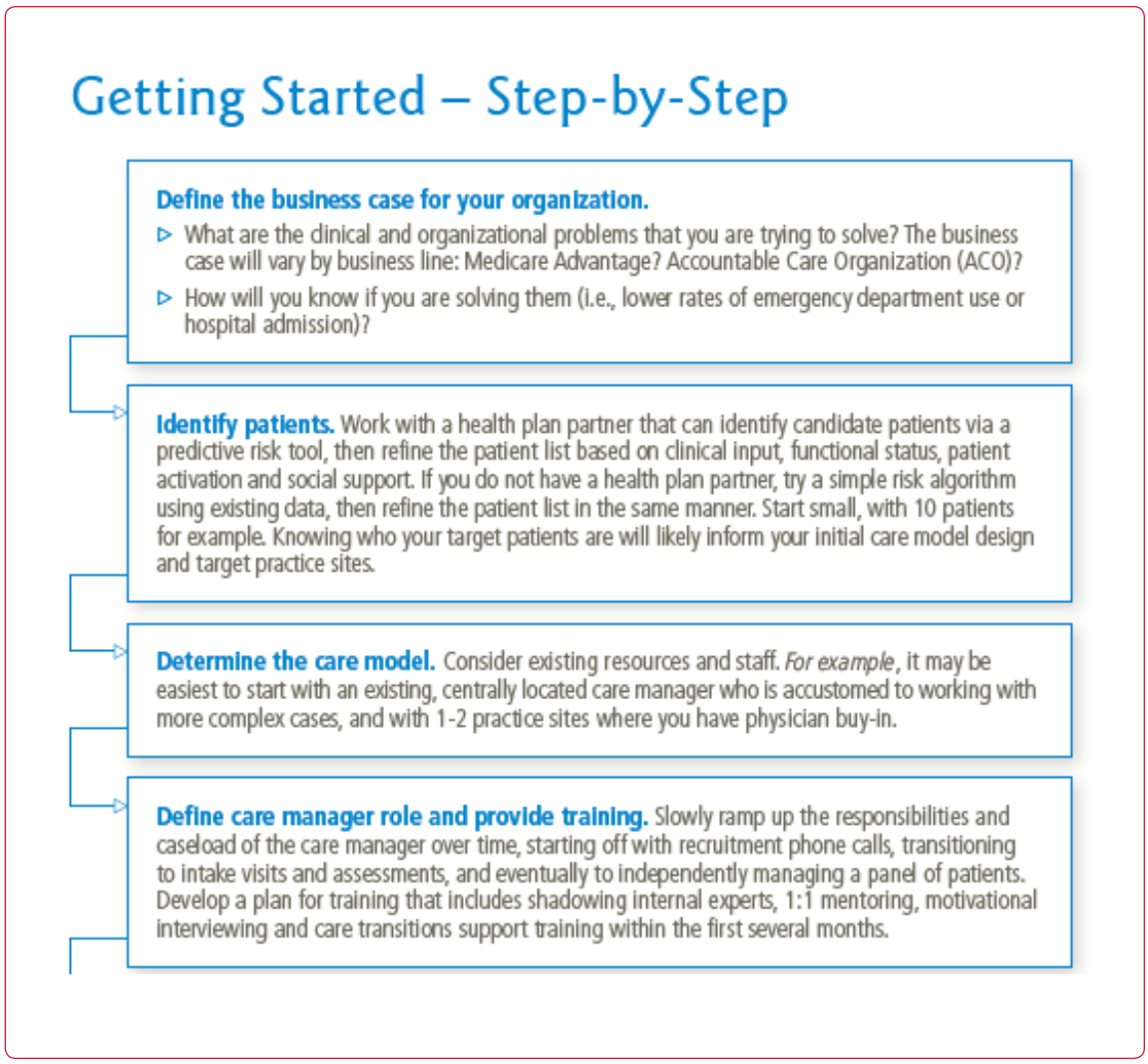
—Care Manager

Community Care of North Carolina (n.d.)—
CCNC Motivational Interviewing (MI) Resource Guide
This resource guide includes a variety of resources, techniques and tools for motivational interviewing, including process flows for conversations, practical stage-based techniques, sample questions, articles, and checklists.
The full guide is available at the link above.



California Quality Collaboration (2012)—Complex Care Management Toolkit

This toolkit is a guide to improving and implementing a complex care management program for individuals with multiple chronic conditions, limited functional status and psychosocial needs. It provides guidance on improving an existing care management program or implementing a new one, and includes numerous tools and resources. **The full toolkit is available at the link above.**



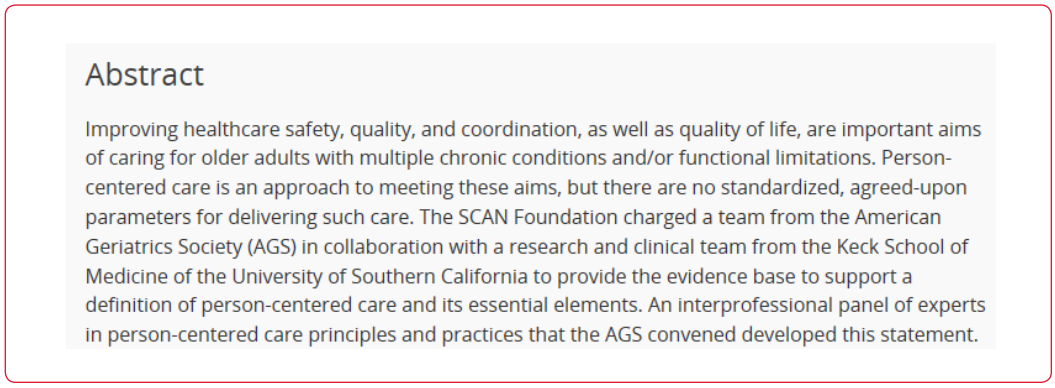
Jamie Ryan, Meredith Brown: The Commonwealth Fund (2016)—
Listening to Those Living with Chronic Conditions
This brief reports findings from focus groups of adults with health conditions that limit their ability to perform daily activities, and their caregivers. It answers the question, "What do individuals with complex needs worry about?" **The full brief is available at the link above.**

Accessing Care

Given their many needs and the frequency of their medical visits, these patients are especially interested in having **easy access** to their doctors and other providers. Common concerns included not being able to get timely appointments, having trouble communicating with their doctors between visits, and waiting a long time to be seen at scheduled appointments. Several reported that during appointments providers seemed rushed and not focused on their complex needs.

"When you are working with doctors at the top medical center, and they are so bogged down with so many patients... **I don't need a lot of time, but I don't always get the time I need** and their head isn't always with my situation.

The American Geriatrics Society Expert Panel on Person-Centered Care (2015)—
Person-Centered Care: A Definition and Essential Elements
This article provides a definition and essential elements of person-centered care, and identifies barriers to achieving it. **The full article is available at the link above.**



Abstract

Improving healthcare safety, quality, and coordination, as well as quality of life, are important aims of caring for older adults with multiple chronic conditions and/or functional limitations. Person-centered care is an approach to meeting these aims, but there are no standardized, agreed-upon parameters for delivering such care. The SCAN Foundation charged a team from the American Geriatrics Society (AGS) in collaboration with a research and clinical team from the Keck School of Medicine of the University of Southern California to provide the evidence base to support a definition of person-centered care and its essential elements. An interprofessional panel of experts in person-centered care principles and practices that the AGS convened developed this statement.

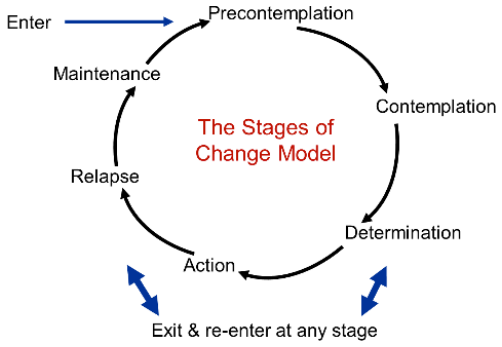
Wayne W. LaMorte, Boston University School of Public Health (2016)—
The Transtheoretical Model (Stages of Change)
This website describes the six stages of change and includes strategies that help people maintain change.
For the full website, visit the source link above.

The Transtheoretical Model (Stages of Change)

The Transtheoretical Model (also called the Stages of Change Model), developed by Prochaska and DiClemente in the late 1970s, evolved through studies examining the experiences of smokers who quit on their own with those requiring further treatment to understand why some people were capable of quitting on their own. It was determined that people quit smoking if they were ready to do so. Thus, the Transtheoretical Model (TTM) focuses on the decision-making of the individual and is a model of intentional change. The TTM operates on the assumption that people do not change behaviors quickly and decisively. Rather, change in behavior, especially habitual behavior, occurs continuously through a cyclical process. The TTM is not a theory but a model; different behavioral theories and constructs can be applied to various stages of the model where they may be most effective.

The TTM posits that individuals move through six stages of change: precontemplation, contemplation, preparation, action, maintenance, and termination. Termination was not part of the original model and is less often used in application of stages of change for health-related behaviors. For each stage of change, different intervention strategies are most effective at moving the person to the next stage of change and subsequently through the model to maintenance, the ideal stage of behavior.

1. Precontemplation - In this stage, people do not intend to take action in the foreseeable future (defined as within the next 6 months). People are often unaware that their behavior is problematic or produces negative consequences. People in this stage often underestimate the pros of changing behavior and place too much emphasis on the cons of changing behavior.
2. Contemplation - In this stage, people are intending to start the healthy behavior in the foreseeable future (defined as within the next 6 months). People recognize that their behavior may be problematic, and a more thoughtful and practical consideration of the pros and cons of changing the behavior takes place, with equal emphasis placed on both. Even with this recognition, people may still feel ambivalent toward changing their behavior.
3. Preparation (Determination) - In this stage, people are ready to take action within the next 30 days. People start to take small steps toward the behavior change, and they believe changing their behavior can lead to a healthier life.
4. Action - In this stage, people have recently changed their behavior (defined as within the last 6 months) and intend to keep moving forward with that behavior change. People may exhibit this by modifying their problem behavior or acquiring new healthy behaviors.
5. Maintenance - In this stage, people have sustained their behavior change for a while (defined as more than 6 months) and intend to maintain the behavior change going forward. People in this stage work to prevent relapse to earlier stages.
6. Termination - In this stage, people have no desire to return to their unhealthy behaviors and are sure they will not relapse. Since this is rarely reached, and people tend to stay in the maintenance stage, this stage is often not considered in health promotion programs.



The Learning Community—for Person Centered Practices (2009)—
Michael Smull introduces person centered thinking tools
This website provides links to nine videos about person-centered thinking. Videos include "Creating person centered plans that make a difference" and "Making person-centered planning mainstream—how to get started." **All videos can be accessed at the link above.**

YouTube

Michael Smull introduces person centered thinking tools

This is a series of nine videos (e.g., The doughnut, Important to and for) on YouTube which have been funded and produced by Helen Sanderson Associates (Copyright 2011). They can be found by clicking on the HSA Channel.

Additional YouTube Videos

Michael Smull - The history of Essential Lifestyle Planning and The Learning Community
www.learningcommunity.us
www.helensandersonassociates.co.uk
Produced by Spoken-Image for Helen Sanderson Associates
Copyright 2009
click on **YouTube**

Support Development Associates, LLC (n.d.)—SDA Library
The SDA library of resources includes a variety of tools, templates, trainings, podcasts and articles about person-centered care. One resource, "Becoming a Person Centered System," identifies best practices.
All materials are available at the link above.

D. Care Transitions

Organizations have a process for managing transitions, identifying problems that could cause unplanned care transitions and, when possible, preventing unplanned transitions.

Minnesota Hospital Association (2011)—Safe Transitions Gap Analysis; Minnesota Hospital Association Safe Transitions of Care Considerations for Organizational Policy Development

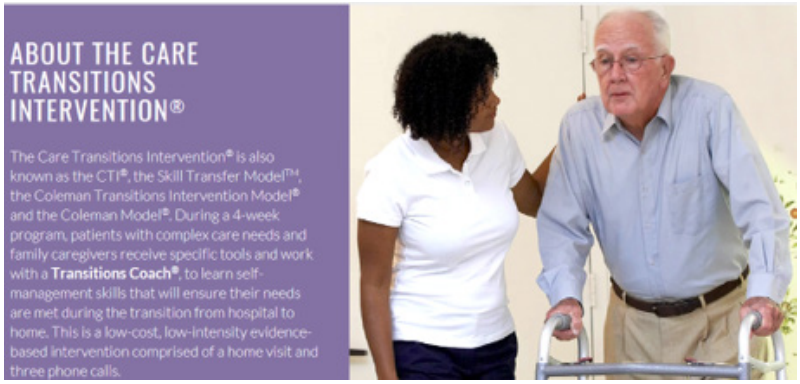
This gap analysis, originally developed for hospitals, can be used to identify opportunities to improve transitions of care. **For background information and the full assessment, visit the source links above.**

SAFE Component	Specific Action	Assessment Question	Yes	No
Safe transition teams S	• Provide support and expectations for SAFE TRANSITIONS champions • Adopt an interdisciplinary team approach to SAFE TRANSITIONS with a designated coordinator • Engage key stakeholders	• Senior Leadership has identified a physician champion(s) and/or senior executive for SAFE TRANSITIONS • Senior Leadership has identified an operational champion(s) for SAFE TRANSTIONS (e.g. Case management Director, Social Worker, Nursing Leader) • The facility has a process in place to partner the physician and operational champions • Senior Leadership has defined roles, set expectations and provides support for the champion(s) • The facility adopts a team approach to safe transitions with an interdisciplinary team to oversee and support the SAFE TRANSITIONS work • The facility has a designated coordinator to oversee SAFE TRANSITIONS implementation (e.g. schedule team meetings, plan staff education) • Individual roles in SAFE TRANSITIONS are clearly defined • Stakeholder representation on team includes all transition settings		
Access to information A	• Verify the completion of SAFE TRANSITIONS • Audit the effective completion of SAFE TRANSTION • Measure the outcomes of SAFE TRANSITIONS • Evaluate the SAFE TRANSTIONS efforts for learning opportunities	Data Collection • The facility has a process in place to audit the completion of SAFE TRANSITIONS through audits • The facility has developed standard criteria for auditors Data Analysis • The facility has a process in place to review and analyze data on a regular basis for learning and improvement opportunities • Data is shared within and across teams on a regular basis • Data is shared with senior leadership on a regular basis • Data is shared with the facility's medical staff on a regular basis		
Facility expectations F	• Set expectations for implementation of SAFE TRANSITIONS for any transition • Expect staff to "speak up" when they become aware of a patient safety issue related to transitions of care.	• Senior leadership has set clear expectations for effective completion of SAFE TRANSITION prior to any transition • Senior leadership has clearly communicated that all staff are expected to speak up and will be supported in speaking up, when safety issues are noted. • The facility has a process in place to institute hard stop for transitions if required components of a safe transition are not addressed/		
Educate staff and patients E	• Provide SAFE TRANSITIONS education for all staff involved in transitions, including practitioner. • Educate patients and families on their role in SAFE TRANSITIONS	• Expectations and supporting education have been incorporated into orientation for new physicians and other practitioners involved in transitions • Ongoing SAFE TRANSITIONS staff education is provided at least annually • Patient/family safe transition education tools are disseminated as appropriate		

The Care Transitions Program, The Division of Health Care Policy & Research, University of Colorado Denver (n.d.)—About the Care Transitions Intervention

This website provides an evidence-based approach to supporting people in transitions across care settings. It describes training and interventions, and provides free tools and resources for download.

All resources are available at the link above.



University of Pennsylvania School of Nursing (n.d.)—NewCourtland Center for Transitions and Health: Transitional Care Model

This website presents an evidence-based approach to care transitions for people with complex needs. The site includes translation tools, including patient screens, recruitment scripts, online seminars, performance improvement processes, documentation systems and monitoring and evaluation protocols for use in practice.

All resources are available at the link above.

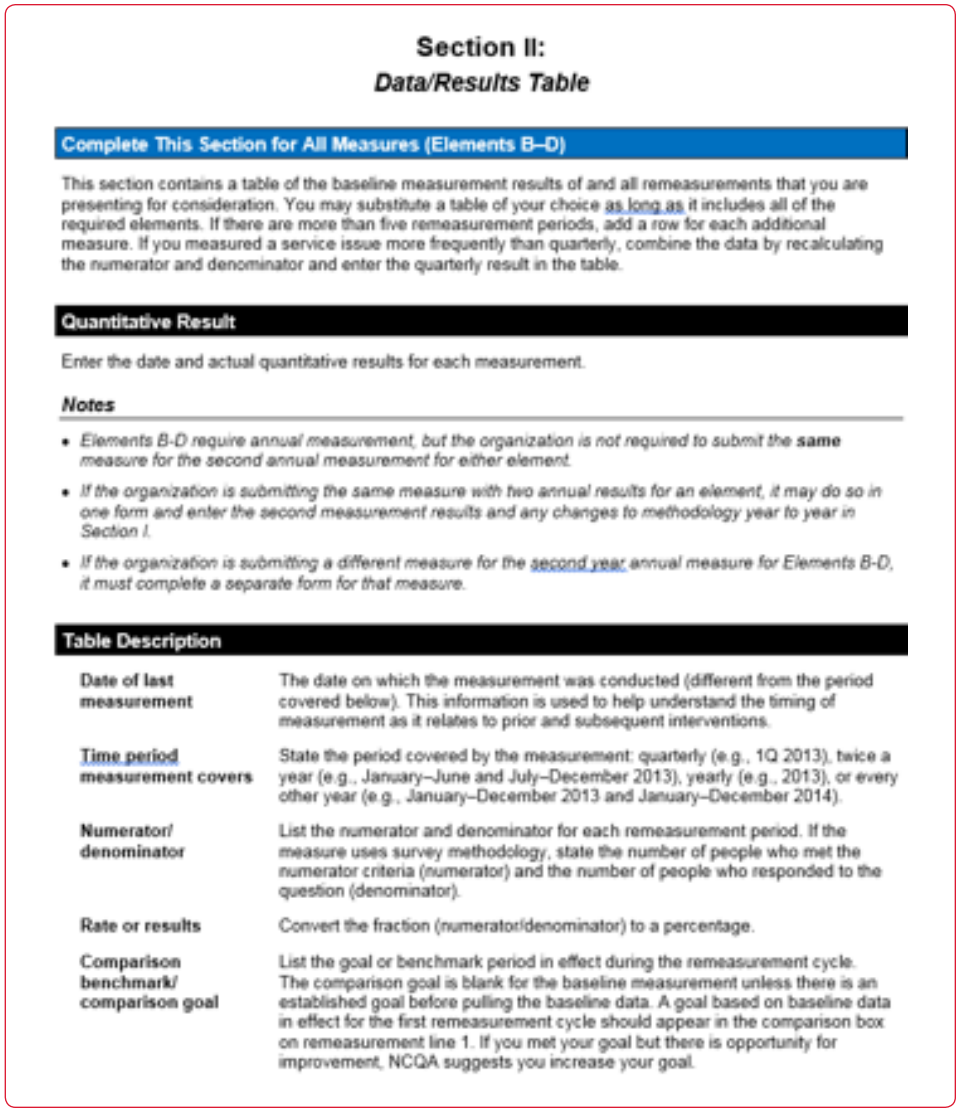
E. Measurement and Quality Improvement

Organizations measure and work to improve participant experience, program effectiveness and active participation rates.

National Committee for Quality Assurance (n.d.)—Quality Improvement Activity (QIA) Form and Instructions for CM LTSS 5 and HPA LTSS 2 B-E: Quality Measurement and Improvement

This tool, adapted from NCQA's Disease Management Accreditation Program, is a guide for completing NCQA's QIA form, which may be used to meet CM LTSS 5 (or LTSS Module 2) Elements B–E.

The full tool is available in Appendix D**.**



Section II:
Data/Results Table

Complete This Section for All Measures (Elements B–D)

This section contains a table of the baseline measurement results of and all remeasurements that you are presenting for consideration. You may substitute a table of your choice as long as it includes all of the required elements. If there are more than five remeasurement periods, add a row for each additional measure. If you measured a service issue more frequently than quarterly, combine the data by recalculating the numerator and denominator and enter the quarterly result in the table.

Quantitative Result

Enter the date and actual quantitative results for each measurement.

Notes

- *Elements B-D require annual measurement, but the organization is not required to submit the* ***same*** *measure for the second annual measurement for either element.*
- *If the organization is submitting the same measure with two annual results for an element, it may do so in one form and enter the second measurement results and any changes to methodology year to year in Section I.*
- *If the organization is submitting a different measure for the second year annual measure for Elements B-D, it must complete a separate form for that measure.*

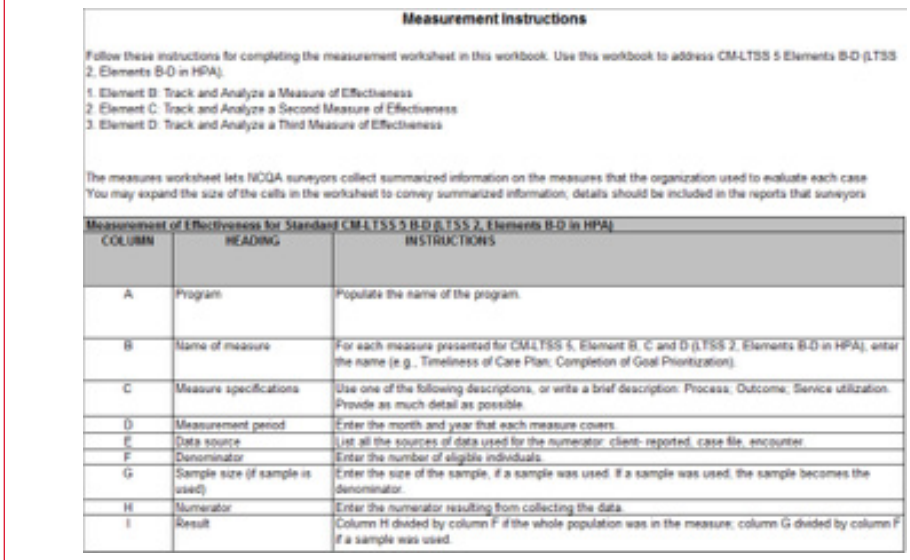
Table Description

Date of last measurement	The date on which the measurement was conducted (different from the period covered below). This information is used to help understand the timing of measurement as it relates to prior and subsequent interventions.
Time period measurement covers	State the period covered by the measurement: quarterly (e.g., 1Q 2013), twice a year (e.g., January–June and July–December 2013), yearly (e.g., 2013), or every other year (e.g., January–December 2013 and January–December 2014).
Numerator/ denominator	List the numerator and denominator for each remeasurement period. If the measure uses survey methodology, state the number of people who met the numerator criteria (numerator) and the number of people who responded to the question (denominator).
Rate or results	Convert the fraction (numerator/denominator) to a percentage.
Comparison benchmark/ comparison goal	List the goal or benchmark period in effect during the remeasurement cycle. The comparison goal is blank for the baseline measurement unless there is an established goal before pulling the baseline data. A goal based on baseline data in effect for the first remeasurement cycle should appear in the comparison box on remeasurement line 1. If you met your goal but there is opportunity for improvement, NCQA suggests you increase your goal.

Quality Measures Workbook

This workbook for tracking and assessing quality measures includes tabs for Measures Instructions, Measures Worksheet, Action & Re-measurement Instructions, Action & Re-measurement Worksheet.

The full tool is available in Appendix D**.**



Measurement Instructions

Follow these instructions for completing the measurement worksheet in this workbook. Use this workbook to address CM-LTSS 5 Elements B-D (LTSS 2, Elements B-D in HPA).

1. Element B: Track and Analyze a Measure of Effectiveness
2. Element C: Track and Analyze a Second Measure of Effectiveness
3. Element D: Track and Analyze a Third Measure of Effectiveness

The measures worksheet lets NCQA surveyors collect summarized information on the measures that the organization used to evaluate each case. You may expand the size of the cells in the worksheet to convey summarized information; details should be included in the reports that surveyors

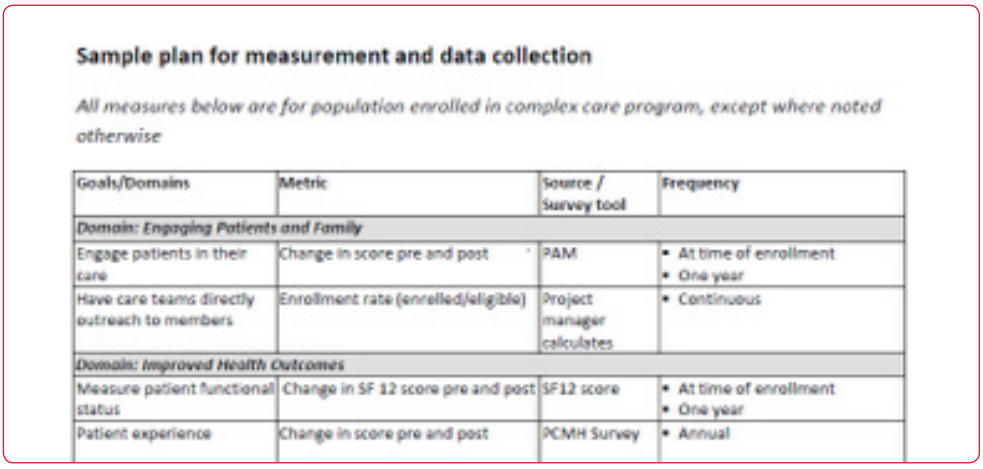
Measurement of Effectiveness for Standard CM-LTSS 5 B-D (LTSS 2, Elements B-D in HPA)

COLUMN	HEADING	INSTRUCTIONS
A	Program	Populate the name of the program.
B	Name of measure	For each measure presented for CM-LTSS 5, Element B, C and D (LTSS 2, Elements B-D in HPA), enter the name (e.g., Timeliness of Care Plan; Completion of Goal Prioritization).
C	Measure specifications	Use one of the following descriptions, or write a brief description: Process; Outcome; Service utilization. Provide as much detail as possible.
D	Measurement period	Enter the month and year that each measure covers.
E	Data source	List all the sources of data used for the numerator: client- reported, case file, encounter.
F	Denominator	Enter the number of eligible individuals.
G	Sample size (if sample is used)	Enter the size of the sample, if a sample was used. If a sample was used, the sample becomes the denominator.
H	Numerator	Enter the numerator resulting from collecting the data.
I	Result	Column H divided by column F if the whole population was in the measure; column G divided by column F if a sample was used.

California Quality Collaborative (n.d.)—Sample Plan for Measurement and Data Collection

This guide to planning data collection for quality improvement includes instructions for developing an aim statement and a sample data collection plan.

The complete resource is available at the link above.



Sample plan for measurement and data collection

All measures below are for population enrolled in complex care program, except where noted otherwise

Goals/Domains	Metric	Source / Survey tool	Frequency
Domain: Engaging Patients and Family			
Engage patients in their care	Change in score pre and post	PAM	• At time of enrollment • One year
Have care teams directly outreach to members	Enrollment rate (enrolled/eligible)	Project manager calculates	• Continuous
Domain: Improved Health Outcomes			
Measure patient functional status	Change in SF 12 score pre and post	SF12 score	• At time of enrollment • One year
Patient experience	Change in score pre and post	PCMH Survey	• Annual

Partners in Care Foundation (2016)—MSSP Performance Improvement Projects

This example details five performance improvement projects led by an organization over a two-year period post-accreditation. **The full tool is available in** Appendix D**.**

QUALITY IMPROVENMENT PROJECT #1: Initiated December 2015, completed March 2016; on-going monitoring

Project Name: Agency Wide Use and Maintenance of Protected Health Information (PHI)

Background:
Baseline metrics gathered between 7/1/2015 and 10/31/3015 indicated a pattern of incidents out of compliance with Partners policies and procedures and NCQA Standards related to PHI. These patterns are quantifiable: unacceptable numbers of unsecure email messages containing PHI have been received from agencies outside of Partners facilities; and qualitative: staff describe inconsistent use of secure-print capability within Partners and inconsistent compliance of secure-print usage, as well as documents left unsecure on staff desks after hours. A Performance Improvement Project (PIP) team formed to conduct a three-month assessment that would inform the development of recommendations and strategies to address the root cause of these issues.

Goals:
Achieve organization-wide PHI/HIPAA Compliance by improving standard policies and procedures for both internal and external transfer of PHI. Ensure staff has proper training on policies and procedures. Provide opportunities for group training to encourage joint learning and problem solving.

- Develop a clear statement of content considered to be PHI;
- Conduct an inventory of guideline documents, standards, and contracts that reference PHI;
- Conduct an Agency-wide inventory of staff in need of secure-print functionality on E-device(s) and training on Agency policies and procedures;
- Refine and Enforce training requirements on PHI, including who should complete training, how often training is needed, which modules should be completed, what content is included, and determining the approved delivery methods and tools for training.

PIP Summary:
This summary report represents outcomes from an agency-wide inventory informing performance improvement strategies. This is the agency's first sponsored performance improvement project (PIP) and the first use of the quality assurance/performance improvement (QAPI) methodology. The results reflect the comprehensive significance of the security of PHI and other sensitive documentation of information across the agency.

National Committee for Quality Assurance (2016)—Checklist for NCQA Data Analysis

This checklist provides detailed instructions and guidance on criteria needed for data anlysis. It includes a checklist for quantitative and qualitative analysis and opportunities for improvement.

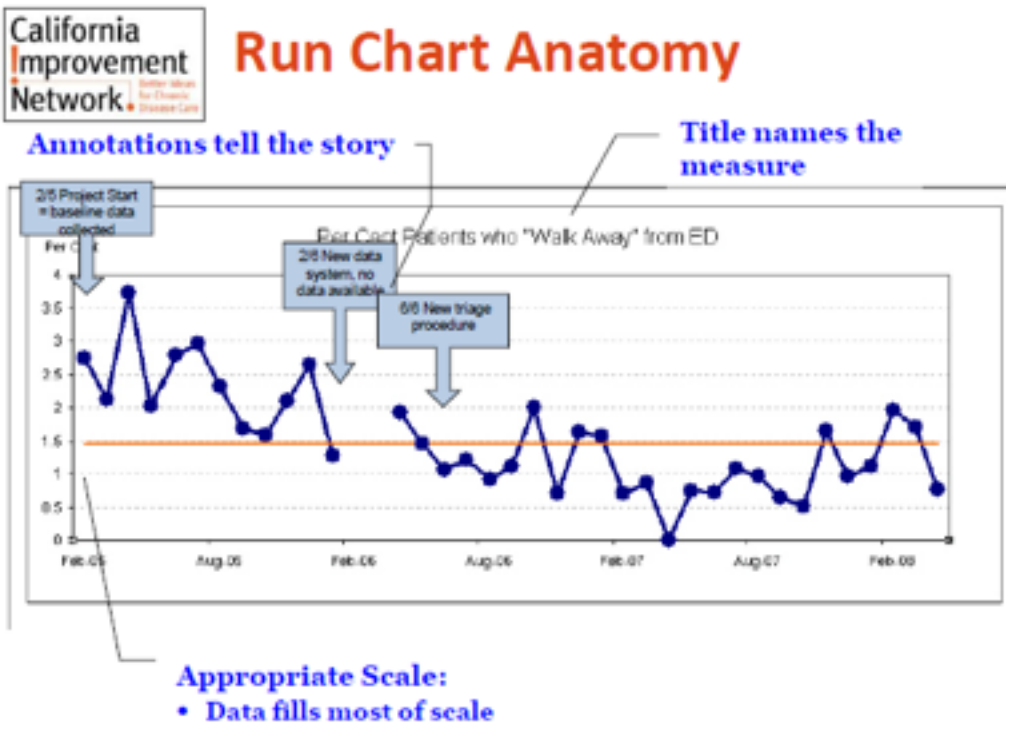
The full tool is available in Appendix D**.**

√	Criteria	Assessment Gaps & Comments
	Data analysis precedes the development and implementation of interventions.	
	QUANTITATIVE ANALYSIS	
	Comparison of results with a goal or benchmark, including drawing a conclusion is required and present. • Appropriate use of mathematics, logic and statistics to draw an appropriate conclusion. • Reporting results is not enough. • Without conclusions, the numbers are simply "reporting" results.	

	Answers the question, "What do the results (numbers) mean?"
	• What is happening?
	• How do the current results compare to prior measurement periods/results?
	  o Getting better? Worse?
	• Has the goal been reached?
	• Is the change statistically significant?
	  o Not required, but often helpful
	• Is the analysis brief and to the point?	

	Goals or benchmarks are present: • Goal (or objective): Set by organization indicating desired level of performance. • Benchmark: Best of the best based on actual performance, cannot be "set". • Threshold: Minimum acceptable performance. Usually identifies the need for intervention.	
	Minimum written conclusion requirements • **Comparison to goal or benchmark** (for both initial measurements and subsequent measurement periods). • **Comparison to prior measurement periods**	

California Quality Collaborative (n.d.)—Using Run Charts: Complex Care Management Toolkit Resource
This resource provides a full-length slide deck on using, developing and understanding run charts for analysis.
The complete resource is available at the link above.



F. Rights and Responsibilities

Organizations communicate the rights and responsibilities of participants in a case management program.

Horizon NJ Health (2014)—MLTSS Non-Medical Professional Provider Manual: Care Management/Authorizations

Below is an excerpt from an MLTSS provider manual that describes critical incidents and reporting requirements.

4.3 Defining Critical Incidents

The CMS (Centers for Medicare and Medicaid Services), as well as the State of New Jersey, requires that measures be employed to protect the health and welfare of Horizon New Jersey Health MLTSS members. This includes guidelines for reporting critical incidents.

Per the state of New Jersey, critical incidents include but are not limited to the following situations:

- Unexpected death of a member
- Missing person or unable to contact
- Suspected or evidenced physical or mental abuse (including seclusion and restraints, both physical and chemical)
- Theft with law enforcement contact
- Law enforcement contact
- Severe injury or fall resulting in the need for medical treatment
- Medical or psychiatric emergency, including suicide attempt
- Medication errors with serious consequences
- Inappropriate or unprofessional conduct by a provider involving the member
- Sexual abuse and/or suspected sexual abuse
- Abuse and neglect, including self-neglect, and/or suspected abuse and neglect
- Elopement/wandering from home or facility
- Eviction/loss of home
- Cancellation of utilities
- Natural disasters
- Frequent falls that result in serious injury
- Repeat hospitalizations for unexplained reasons
- Failure of a member's Backup Plan
- The potential for media involvement
- Other (explain)

4.4 Reporting Requirements for Critical Incidents

MLTSS providers with suspicion or evidence of critical incidents must report them to Horizon NJ Health within one business day of discovery. Upon discovery of a critical incident, providers are to take steps to prevent further harm to members and promptly respond to these members' needs. These steps may include reporting potential violations of criminal law to law enforcement authorities.

Providers should contact the following appropriate authorities, as applicable, including but not limited to:

- The designated County Adult Protective Services (APS) agency. For a listing, contact the NJ State Division of Aging Services at 1-800-792-8820.
- The NJ Office of the Ombudsman for Institutionalized Elderly (OOIE) at 1-877-582-6995
- The NJ Division of Child Protection and Permanency Child Abuse Hotline at 1-877-652-2873

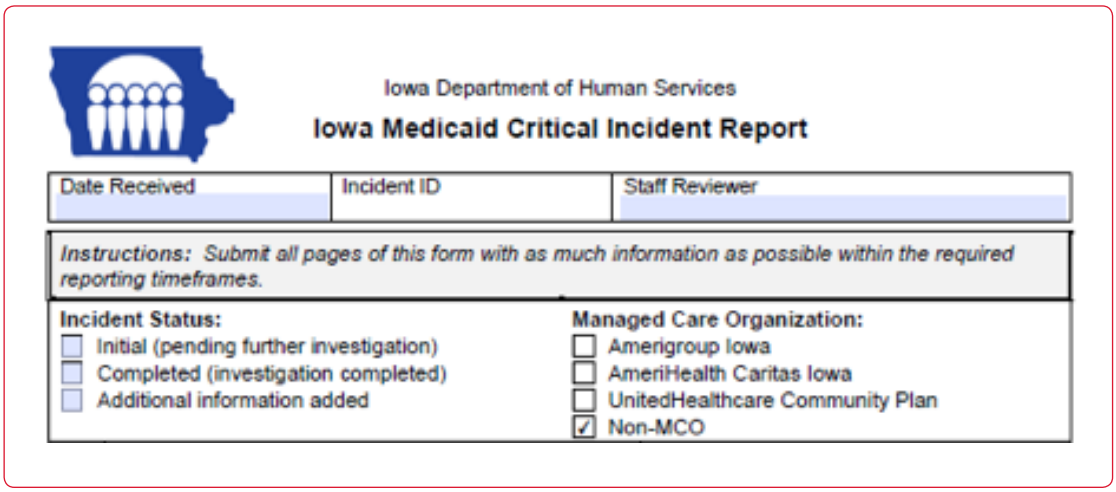
In addition, providers are required to complete the MLTSS Critical Incident Reporting form, available at horizonnjhealth.com, and fax to the Horizon NJ Health Quality Management Department, along with any supporting documentation, at 609-583-3003.

Horizon NJ Health's Quality staff will subsequently contact/follow up with the provider as warranted, and will retain subsequent Provider Investigation Findings and Resolution summaries from providers to ensure incidents are resolved promptly though appropriate referrals and corrective action. The Horizon NJ Health Quality staff will notify the State of New Jersey of any critical incidents via a state-specified web-based system.

MLTSS providers who have reported critical incidents are required to independently conduct an internal critical incident investigation and submit a report on their findings to Horizon NJ Health. The report should be submitted no longer than 15 calendar days after the date of the incident or discovery of its occurrence. Under extenuating circumstances, but only with the approval of Horizon NJ Health, the report can be submitted within 30 calendar days after the date of the incident.

Iowa Department of Human Services (2017)—Iowa Medicaid Critical Incident Report

This report form provides a detailed example of reporting a critical incident. It includes provider/case manager and member information, a detailed description of the incident and a report on the resolution. **The complete version of the report is available at the link above.**



Iowa Department of Human Services

Iowa Medicaid Critical Incident Report

Date Received	Incident ID	Staff Reviewer

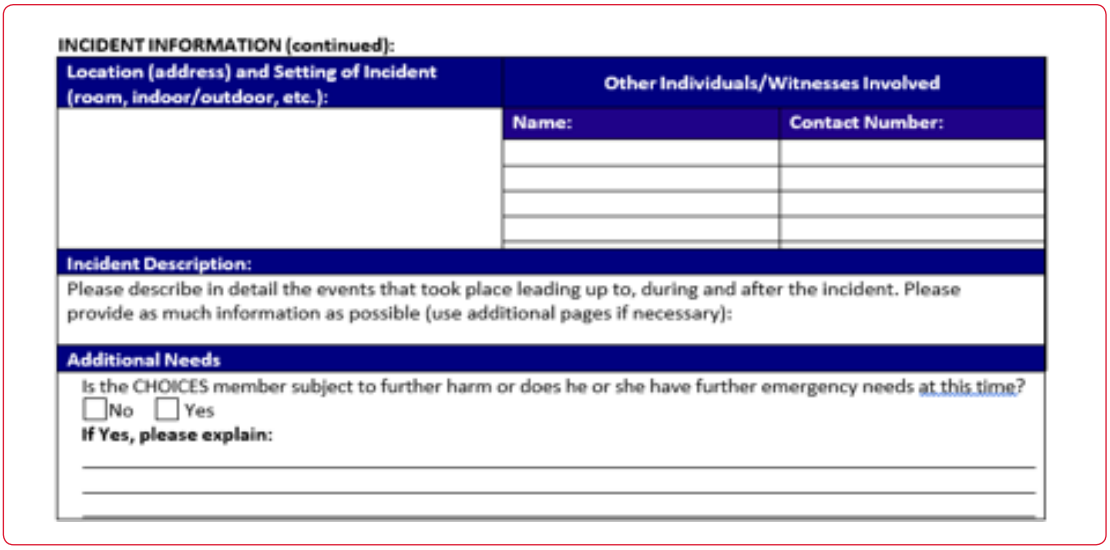
Instructions: Submit all pages of this form with as much information as possible within the required reporting timeframes.

Incident Status:
- ☐ Initial (pending further investigation)
- ☐ Completed (investigation completed)
- ☐ Additional information added

Managed Care Organization:
- ☐ Amerigroup Iowa
- ☐ AmeriHealth Caritas Iowa
- ☐ UnitedHealthcare Community Plan
- ☑ Non-MCO

Amerigroup RealSolutions in healthcare (2017)—CHOICES Critical Incident Report Form

This form provides an example of reporting a critical incident for providers and/or care coordinators. It includes sections for member and provider information and detailed incident information, and requirements for completing the form. **The full tool is available in** Appendix E**.**



INCIDENT INFORMATION (continued):

Location (address) and Setting of Incident (room, indoor/outdoor, etc.):	Other Individuals/Witnesses Involved	
	Name:	Contact Number:

Incident Description:

Please describe in detail the events that took place leading up to, during and after the incident. Please provide as much information as possible (use additional pages if necessary):

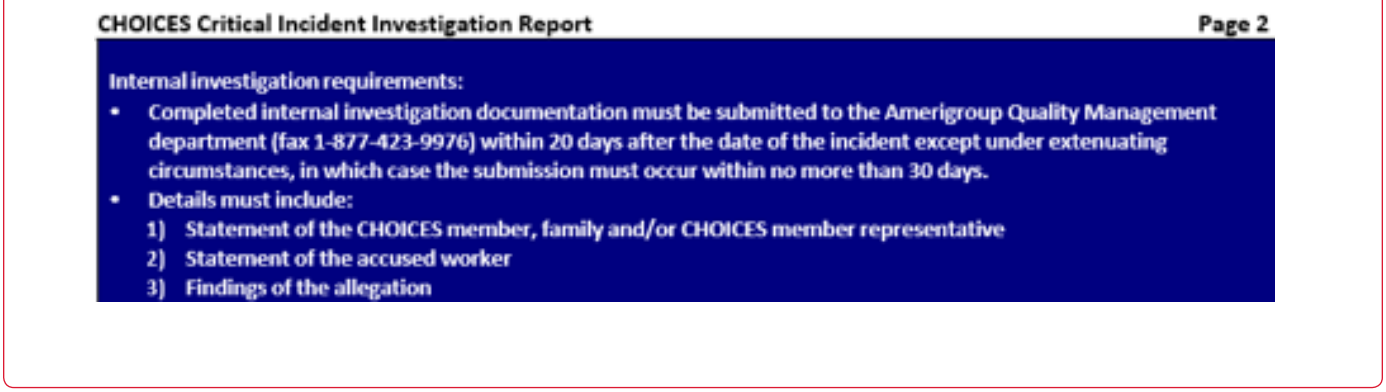
Additional Needs

Is the CHOICES member subject to further harm or does he or she have further emergency needs at this time?

☐ No ☐ Yes

If Yes, please explain:

Amerigroup RealSolutions in healthcare (2017)—
CHOICES Critical Incident Investigation Report
This form provides an example of a critical incident investigation for providers and/or care coordinators. **The full tool is available in** Appendix E**.**



CHOICES Critical Incident Investigation Report **Page 2**

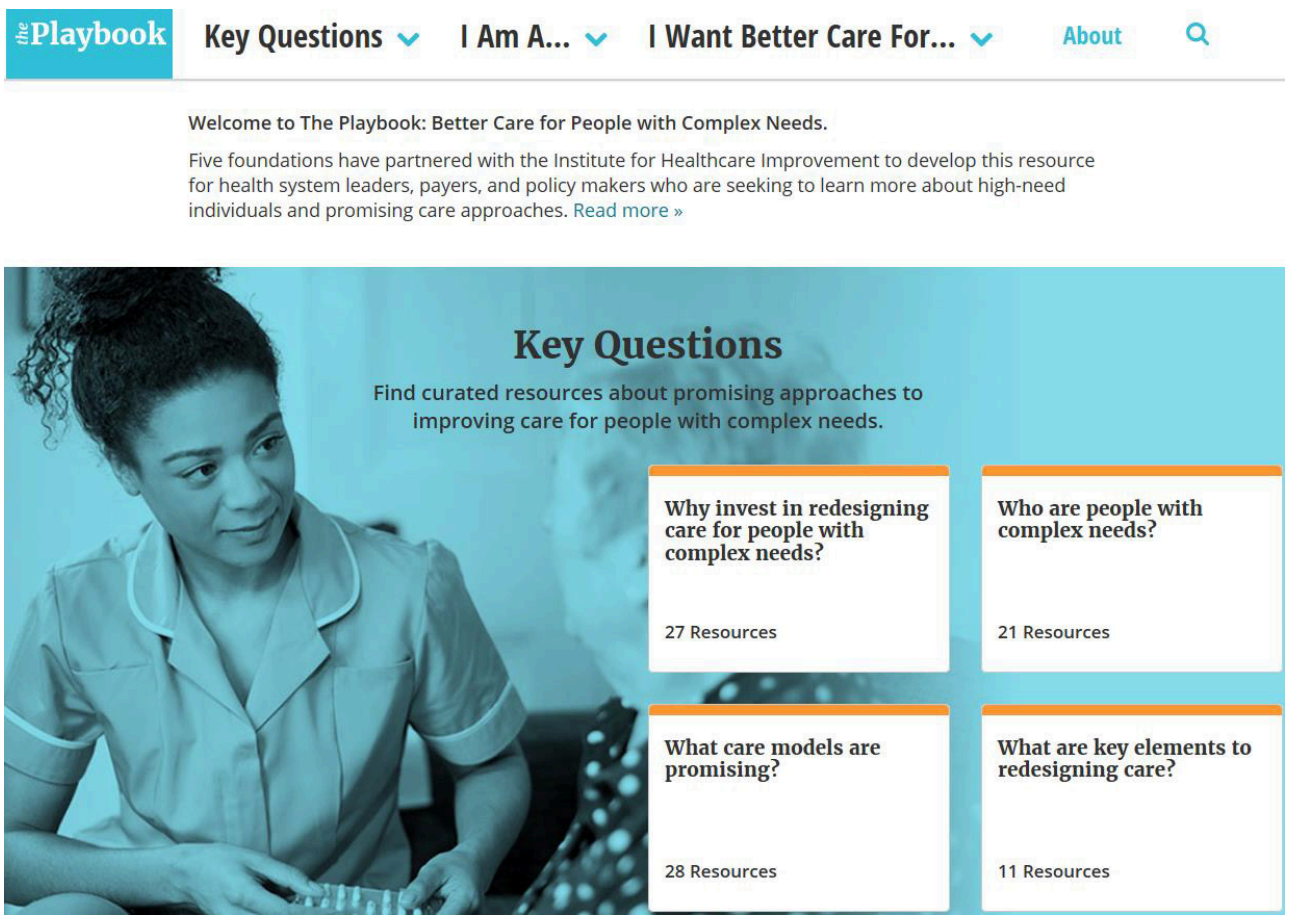
Internal investigation requirements:

- **Completed internal investigation documentation must be submitted to the Amerigroup Quality Management department (fax 1-877-423-9976) within 20 days after the date of the incident except under extenuating circumstances, in which case the submission must occur within no more than 30 days.**
- **Details must include:**
  1) **Statement of the CHOICES member, family and/or CHOICES member representative**
  2) **Statement of the accused worker**
  3) **Findings of the allegation**

G. General and Cross-Cutting Resources

Resources in this section relate to topics across multiple LTSS Standards.

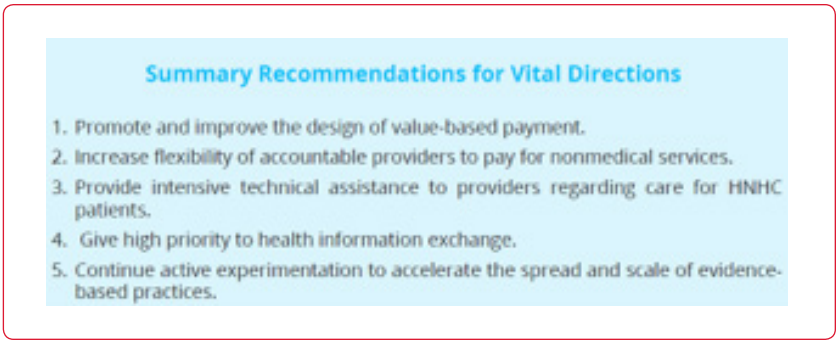
Institute for Healthcare Improvement (2017)—
The Playbook: Better Care for People with Complex Needs
The Playbook includes a variety of resources for health system leaders, policy makers and payers. It offers guidance on identifying and understanding people with complex needs and creating approaches to improve their care. The website provides resources that answer key questions about care for people with complex needs. **The complete toolkit is available at the link above.**



California Quality Collaborative (2016)—Intensive Outpatient Care Program (IOCP) Toolkit
This toolkit focuses on person-centered care, specifically for organizations serving adults 65 and over with the greatest health care needs. It includes multiple resources for organizations in the developmental process of an intensive outpatient care program.
The complete toolkit is available at the link above.

National Academy of Medicine (2016)—Tailoring Complex Care Management, Coordination, and Integration for High-Need, High-Cost Patients

This report answers the question, "What are the policy recommendations to potentially improve care for the high-need, high-cost patient population?" and provides five key recommendations. **The full report is available at the link above.**

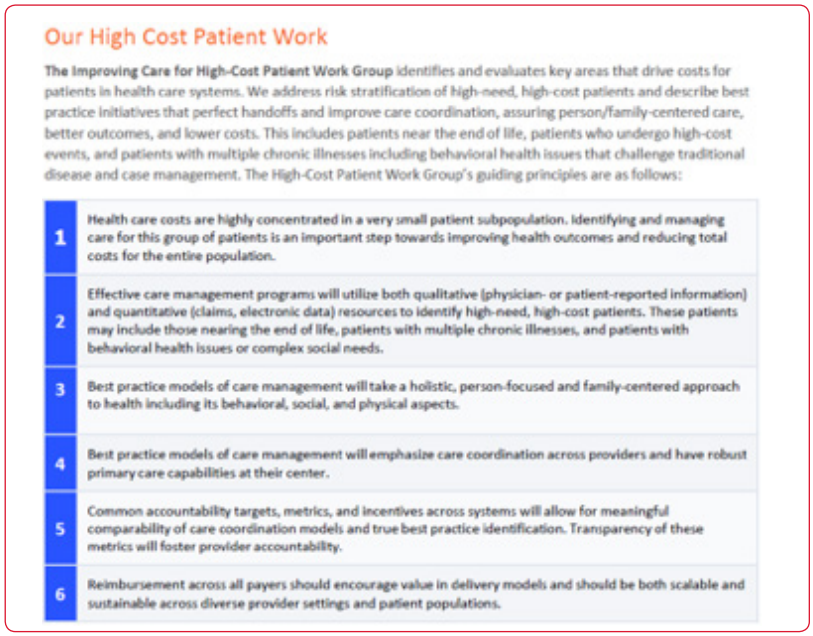


Summary Recommendations for Vital Directions

1. Promote and improve the design of value-based payment.
2. Increase flexibility of accountable providers to pay for nonmedical services.
3. Provide intensive technical assistance to providers regarding care for HNHC patients.
4. Give high priority to health information exchange.
5. Continue active experimentation to accelerate the spread and scale of evidence-based practices.

The Health Care Transformation Task Force (2016)—Developing Care Management Programs to Serve High-Need, High-Cost Populations

This report answers the following questions: 1.) What are the features of successful care management programs for high-need patients?; 2.) What are some ways to engage patients and caregivers in the continuum of care?; 3.) What are some examples of successful programs? **The full report is available at the link above.**



Our High Cost Patient Work

The Improving Care for High-Cost Patient Work Group identifies and evaluates key areas that drive costs for patients in health care systems. We address risk stratification of high-need, high-cost patients and describe best practice initiatives that perfect handoffs and improve care coordination, assuring person/family-centered care, better outcomes, and lower costs. This includes patients near the end of life, patients who undergo high-cost events, and patients with multiple chronic illnesses including behavioral health issues that challenge traditional disease and case management. The High-Cost Patient Work Group's guiding principles are as follows:

1. Health care costs are highly concentrated in a very small patient subpopulation. Identifying and managing care for this group of patients is an important step towards improving health outcomes and reducing total costs for the entire population.
2. Effective care management programs will utilize both qualitative (physician- or patient-reported information) and quantitative (claims, electronic data) resources to identify high-need, high-cost patients. These patients may include those nearing the end of life, patients with multiple chronic illnesses, and patients with behavioral health issues or complex social needs.
3. Best practice models of care management will take a holistic, person-focused and family-centered approach to health including its behavioral, social, and physical aspects.
4. Best practice models of care management will emphasize care coordination across providers and have robust primary care capabilities at their center.
5. Common accountability targets, metrics, and incentives across systems will allow for meaningful comparability of care coordination models and true best practice identification. Transparency of these metrics will foster provider accountability.
6. Reimbursement across all payers should encourage value in delivery models and should be both scalable and sustainable across diverse provider settings and patient populations.

The Health Care Transformation Task Force (2016)—Payment to Promote Sustainability of Care Management Models for High-Need, High-Cost Patients

This report informs the work of health care organizations, systems and payers aiming to improve care and reduce costs for high-need, high-cost patients. It outlines payer and provider partnerships that encourage improvement of care through value-based payment models.

The full report is available at the link above.

Table 2. Sample of Representative Payment Models Received by Providers to Support High-Need, High-Cost Patient Models

	Category 1 Fee-for-Service – No link to Quality or Value	Category 2 Fee-for-Service Linked to Quality and Value	Category 3 Alternative Payments Based on a Fee-For-Service Architecture	Category 4 Population-Based Payment
Medicare		St. Joseph: CPT 99490	Providence: Shared Savings ACO (upside—3a) Atrius Health: Pioneer ACO Montefiore: Pioneer ACO	Advocate: Full risk for Medicare Advantage Providence: Full risk for Medicare Advantage St. Joseph: Full risk for Medicare Advantage Atrius Health: Full risk for Medicare Advantage Montefiore: Full risk for Medicare Advantage
Commercial		Advocate: Humana PPO,BCBS PPO (self-insured pop w/o shared savings) St Joseph: Anthem--case mgmt. fee paid on top of FFS payment with small withhold based on value.	Advocate: United, Cigna PPOs BCBS-IL PPO Providence: Direct-to-employer ACO contracts St. Joseph: CareConnect Montefiore: shared savings arrangements	Advocate: Blue Care Direct, Advocate Associates EPO/HMO BCBS-IL HMO, BCBS-IL BlueAdvantage HMO, BCBS-IL Blue Precision HMO Humana HMO (partial risk for ambulatory services) Montefiore: full delegated risk
Medicaid	Advocate: Illinois Medicaid	Advocate: Illinois Medicaid	Montefiore: shared savings arrangements	Montefiore: full delegated risk

Case Study: Delivery System Receiving Payments in Multi-Payer Environment

Virtually all health care delivery systems reiterate both the importance and challenge of multi-payer alignment. A salient example comes from St. Joseph Health, an integrated health care delivery system providing a full range of care from facilities including 14 acute care hospitals, home health agencies, hospice care, outpatient services, skilled nursing facilities, community clinics, and physician organizations. St. Joseph's delivers care across a variety of urban centers, smaller cities, and rural communities in California, Texas, and New Mexico.

St. Joseph offers the CareConnect program, an intensive outpatient care management for both Medicare and commercial high-need, high-cost patients. St. Joseph is reimbursed for its high-cost patient interventions under a variety of payment methods spanning Categories 2-4 in the LAN APM framework (see Table 2). The organization has found full capitated payment arrangements (currently covering about 30 percent of its patient population) are the most conducive to both the foundational and operational requirements of its care coordination work. Examples of the former include investments of the data sharing infrastructure necessary for performance monitoring and improvement. Expansion and coordination of ancillary services like mental health and social support also work best in a full-risk ACO environment.

The Synthesis Project, The Robert Wood Johnson Foundation (2009)—
Care Management of Patients with Complex Health Care Needs

This report provides evidence that care management programs can improve quality of care, and aims to answer two questions: 1.) What does the evidence show about care management programs for persons with complex needs? What works, and what doesn't work?; 2.) How can payment systems and policies be reformed to encourage good care management? **The full report is available at the link above.**

Care management of patients with complex health care needs

By Sarah Goodell, M.A., Thomas Bodenheimer, M.D., M.P.H., and Rachel Berry-Millet, B.A. based on a research synthesis by Bodenheimer and Berry-Millet

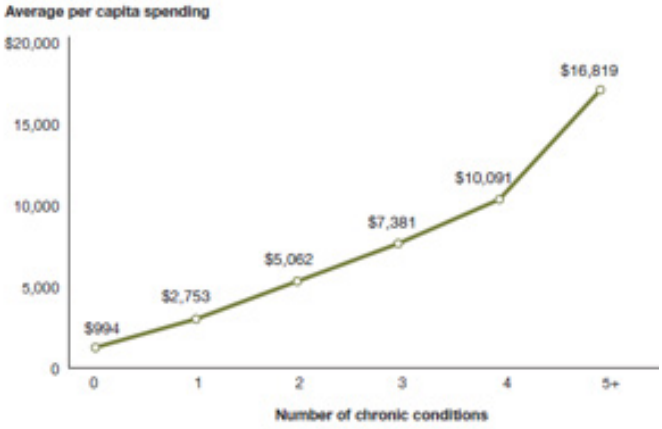
SUMMARY OF KEY FINDINGS

- **Care management improves quality, but it may take time to see results.** Studies that followed patients for longer periods were more likely to show quality improvements.
- **Care management programs targeting the hospital-to-home transition were the most successful in reducing costs.** Cost reduction was achieved through reduced readmissions.
- **Successful care management programs include specially trained nurse care managers, in-person encounters and physician involvement.** The use of coaching has also proven to be an effective approach.
- **Current payment policies do not support the adoption of care management.** Care management activities often are not reimbursed and successful care management programs

Why is this issue important to policy-makers?

- A high percentage of health care expenditures are associated with a small proportion of the population.
- Health care spending for people with five or more chronic conditions is 17 times higher than for people with no chronic conditions (Figure 1).
- Care management is a delivery innovation that may be able to reduce costs while improving quality for people with multiple chronic conditions.

Figure 1: Average per capita spending by number of chronic conditions



Source: Anderson, 2007 (Reference 1)

What is care management?

Care management is a set of activities designed to assist patients and their support systems in managing medical conditions more effectively. The goals of care management are to improve patients' functional health status, enhance coordination of care, eliminate duplication of services, reduce the need for expensive medical services, and increase patient engagement in self care (Reference 2).

How are patients identified for care management?

Identifying patients most likely to benefit is a critical component of care management. Care management is a relatively intensive and costly service. Offering care management to patients who are not expected to be high utilizers of hospital, specialty and emergency department care would not reduce costs. Similarly, care management for patients too sick to benefit is ineffective.

The Commonwealth Fund (2014)—
Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?
This brief reviews 18 successful complex care management (CCM) programs for high-need, high-cost patients, and provides guidance on best practices and different approaches to CCM.
The full brief is available at the link above.

WHAT MAKES FOR AN EFFECTIVE CCM PROGRAM?

Following is a summary of key findings based on our investigation of effective CCM programs.

CCM programs must be tailored to their particular context. Contextual factors include practice size, location in an urban or rural area, and program sponsorship and governance.

- Small, independent practices, which are less likely to have a sufficient number of complex patients to justify investment in a CCM team, need to share CCM resources with each other. Regional care management entities that serve multiple practices are particularly well suited for areas where smaller practices predominate—for example, in rural locales.
- CCM programs in rural settings require greater team resources or smaller caseloads to offset the increased travel time and relative scarcity of community resources.
- Larger practices with sufficient numbers of complex patients should have embedded care managers at primary care practices and other key sites. Some CCM team members can be shared across practices.
- Primary care teams familiar with the principles of team-based care and quality improvement processes are likely to be supportive of CCM programs. Conversely, CCM team members may facilitate practice change at primary care sites.

Exhibit 1. Operational Control in CCM Programs: Advantages/Disadvantages of Different Approaches

Operational Control Type	Advantages	Disadvantages
Payer-operated	• Greater flexibility • Access to financial resources	• Greater challenges engaging patients and providers • Limit use of CCM resources to their members
Practice-operated	• Greater opportunity for primary care integration	• Care managers pulled from care management tasks to cover day-to-day clinic duties
Delivery system-operated	• Central oversight of care management activities • Economies of scale—formal training opportunities, peer-learning, improved data integration, and greater connectivity with providers/care managers across the delivery system	• May limit use of CCM resources to specific members for which the delivery system is at risk
Independent Regional Care Management Organization	• Allow implementation in places where a small number of complex patients make it difficult to embed CCM teams into practices • Economies of scale—formal training opportunities, peer-learning, improved data integration, and quality improvement capacity	• Greater challenges engaging patients and providers • Limit use of CCM resources to their members

SECTION 5:

Preparing for the Accreditation Survey

A. Application

Sample Preparation Timeline:

After completing the gap analysis, Elder Services AAA has decided it would like to pursue accreditation by December 2017. When talking to NCQA's Application and Scheduling team, Elder Services AAA learned that the accreditation process takes roughly 9 months, which includes preparation and NCQA reviews. The Application and Scheduling team also explained the application process and offered guidance to help Elder Services AAA select a survey submission date. Elder Services AAA has selected October 9, 2017, to submit their accreditation survey to NCQA. In preparation, Elder Services AAA begins its project plan to meet that target date.

Below is an example of how Elder Services AAA's accreditation team planned their preparation.

Survey Preparation Timeline

Date	Task/Activity	Responsible Party	Notes and Follow-Up
October 2016	Learned about NCQA Accreditation process • Download application • Purchase standards Identified Accreditation Team members	Sally Jones	Accreditation Team • Sally Jones (Lead) • Linda Morton • John Smith • Sam Edwards
November 2016	Contacted NCQA's Customer Engagement team with questions Held first Accreditation Team meeting to review the standards • Assigned standards to team members to review • Developed meeting schedule • Outlined communication plan to leadership team and staff	Accreditation Team	Heard about education webinars for the CM-LTSS standards. Scheduled team meeting to learn more.
December 2016	Completed review of standards and gap analysis Held a meeting with Leadership, who supported us proceeding with the process based on initial findings. Submitted application, application fee and agreement; worked with NCQA Applications and Scheduling Account Representative (ASAR) to select survey submission date: October 9, 2017.	Accreditation Team	Needed to develop new policies for how we handled person-centered care planning and care transitions. Assigned person-centered care plan to Linda and care transitions to Sam. They discussed with their teams for feedback. Assigned Sally to report to leadership. Assigned John to manage project workplan.

Date	Task/Activity	Responsible Party	Notes and Follow-Up
January 2017	Started organizing documentation to make sure our information meets the 6-month look-back period. Reviewed standards that required reports and looked for where we have that information available or need to create. Held a meeting with case managers to discuss person-centered care planning and care transitions and recommended changes to policies and procedures to get buy-in and feedback. Heard from our assigned Accreditation Survey Coordinator (ASC), who will be our point of contact through the accreditation process. Established a My.NCQA.org account. Submitted a few questions to the Policy Clarification Support (PCS) system for additional clarity on a few standards.	Accreditation Team	Ensure all new policies have been documented and implemented by April 9, 2017 because our survey is October 9, 2017. Invited a subset of case managers to participate in the development and testing of the new processes.
February 2017	Met with Leadership, case managers and other team members about updates to initial recommended changes. Pulled preliminary reports to see what we could report. Met with IT to discuss systems updates to help better connect our systems and data. Submitted new questions to PCS.	Accreditation Team	Made updates to policies.
March 2017	Started revising documents. Updated policy for tracking background checks. Updated fields in the assessment tools. Held training on social determinants of health. Pulled and started generating reports.	Accreditation Team	Updated brochures to support the cultural and linguistic needs of our clients.
April 2017	Finalize all new policies and procedures by April 9. Make sure all policies included implementation and revision dates.	Accreditation Team	
May 2017	Continue organizing materials.	Accreditation Team	
June 2017	Update Leadership and staff.	Accreditation Team	
July 2017	Receive information from Accreditation Survey Coordinator about the survey process. Continue preparing documentation.	Accreditation Team	

Date	Task/Activity	Responsible Party	Notes and Follow-Up
August 2017	Include our list of programs we are getting accredited, send hotel suggestions and draft onsite review agenda.	Accreditation Team	Will receive invoice from NCQA for remaining survey fee around August 9, which is 60 days prior to our survey date.
September 2017	Finish attaching documentation to ISS as completed.	Accreditation Team	
October 9, 2017	Submit Interactive Survey System (ISS) tool.	Linda Morton (lead) Sam Edwards (backup)	Plan for NCQA visit in 7 weeks. Expecting list of 40 files for site visit from NCQA 10 business days prior to the onsite review.
After We Submit the Survey			
November 8, 2017	Hold survey conference call with NCQA Survey Team.	Accreditation Team	
November 13, 2017	Start pulling the files for the onsite review.	Accreditation Team	
November 27, 2017	NCQA 1-day onsite review.	Accreditation Team & Leadership	Will receive decision 34 days after on-site visit.

B. Document Preparation

Document Preparation Guidelines

An important part of any NCQA survey is document preparation. NCQA determines if an organization meets a standard or element based on what the organization's documents—such as policies, program descriptions, activity reports, member materials, and other work products—demonstrate. The documents show what you as an organization do.

How you prepare those documents and present them to NCQA, how you tell your story, can make it easier for the NCQA survey team to confirm that you meet the standards. This can result in a simpler and more streamlined survey experience, with fewer requests from the survey team for clarification or additional information. Your objective should be to provide the NCQA survey team with the information necessary to accurately evaluate performance against the NCQA standards in as directed and efficient a manner as possible.

Keep in mind that the goal of the surveyor is to confirm compliance with the requirements; therefore, the clearer it is that the intent is met; the easier it is for the surveyor to confirm compliance on behalf of the organization. **However, the organization is ultimately responsible for documenting compliance and directing the surveyors to that documentation.**

The purpose of this document is to provide guidance on preparing documents as well as on writing compliance statements which help the surveyor navigate your documents.

It has three sections:

- **How NCQA Standards are Structured:** This section provides an overview of the components of a standard and its elements, with an emphasis on how to determine what documentation is needed.
- **Document Preparation:** This section describes how to prepare documents, with suggestions on how to compile information, highlight key sections in documents and direct surveyors to the specific information that demonstrates you meet an element. It also explains how NCQA will handle situations where it cannot find evidence of compliance in the documentation—either because it does not appear to be there or because the documents are not presented in a manner that makes it easy to find.
- **Compliance Statements:** This section provides an overview of what a compliance statement is and how it assists NCQA in the review of your documents. It also provides examples of how to compose a compliance statement.

How NCQA Standards are Structured

In order to know what type of information and documentation to provide to the survey team, it is important to understand how the standards are structured. Each NCQA standard includes the following key information:

- **Standard Statement:** The actual statement of the standard that is a description of the acceptable performance or results.
- **Intent Statement:** The statement that describes the importance, purpose and meaning of the standard.
- **Element:** The component of a standard that is scored and provides details about performance expectations. NCQA evaluates each element within a standard to determine the degree to which the organization meets the requirements within the standard.
- **Factor:** An item within an element that is scored. For example, an element may require the organization to demonstrate that a specific document addresses four items; each item is a factor.
- **Data Source:** the types of documentation or evidence that the organization must use to demonstrate compliance with an element. NCQA defines four types of data sources:

  1. **Documented process:** Policies and procedures, process flow charts, protocols and other mechanisms that describe the actual process used by the organization.
  2. **Reports:** Aggregated sources of evidence of action or compliance with an element, including program evaluation management reports; key indicator reports; summary reports from member reviews; system output giving information like number of member appeals; minutes; and other documentation of actions that the organization has taken.
  3. **Materials:** Prepared materials or content that the organization provides to its members or practitioners including written and electronic communication, information from Web sites, scripts, brochures, newsletters and clinical guidelines.

4. **Records or Files:** Actual records or files such as UM denial, complex case management, appeal, credentialing, disease management or wellness and health promotion files that show direct evidence of action or compliance with an element.

If multiple data sources are listed for an element, the explanation section provides direction on what evidence the organization must provide to meet the requirements.

- **Scope of Review:** The extent of the organization's services evaluated during an NCQA survey. The scope of review varies depending on specific elements and how the specific product and product lines are administered.
- **Look-back Period:** The period of time for which NCQA evaluates an individual or organization's documentation to assess performance against an element. NCQA measures the look-back period from the point of the organization's submission of the completed Survey Tool. Unless otherwise noted, organizations must meet the requirement throughout the look-back period.
- **Explanation:** Specific requirements that the organization must meet, and guidance for demonstrating performance against the element.
- **Examples:** Descriptive information illustrating performance against an element's requirements. Examples are provided for guidance only and are not specifically required or all-inclusive.

Be sure to consider all pertinent information provided by NCQA under each standard and element in the Survey Tool (i.e. each of the information sources described in the section above). For example, if the data source specifies "documented process" and the organization provides a report, full compliance is not demonstrated. Likewise, if the look-back period specifies 24 months, and the organization only provides evidence of completion of the activities within the last 12 months prior to the survey date, full compliance is not demonstrated.

Document Preparation

NCQA surveyors serve as fact finders for organizations, verifying that that the documentation presented meets the intent of the requirement. They review what the organization presents in order to provide their findings and recommendations to NCQA's Review Oversight Committee.

The organization's obligation is to present the documentation that demonstrates compliance and to do so in a manner that facilitates review by the NCQA survey team. The organization is expected to:

- Provide the required documents
- Present them in an organized, readable format
- Limit documentation to the minimum necessary to demonstrate compliance
- Use available software features and tools (such as highlighting and comments) to direct the surveyors to evidence of compliance.

If the surveyors do not find evidence of compliance in the documents, they will ask for clarification and provide the organization an opportunity to respond. The organization is not summarily found non-compliant without a discussion

of the issues However, when numerous documents are provided or clear evidence of compliance is not obvious to the surveyor, NCQA reserves the right to go back to organizations, to seek clarifying information and request the organization be more concise in demonstrating compliance.

The onus is on the organization to demonstrate compliance, not on the team to find compliance.

What Is the Best way to Prepare Documentation for the Survey Team?

It is important that documents are prepared for the survey team to review efficiently. NCQA requires that you do the following:

- Reference the specific page number(s) and paragraph to which you want to draw the surveyor's attention.
- Designate each document as "primary" or "secondary" in the ISS Survey Tool. If you are considering using the "Supporting" designation, NCQA encourages the organization to consider if the document is truly necessary to demonstrate compliance.

NCQA strongly suggests the following tools available in common software be used to prepare the documentation for the survey team.

- Highlight or underline the key text in the document to draw the surveyor's attention to the sections that demonstrate compliance.
- Create "hyperlinks" or "bookmarks" in the document to automatically take the surveyor to highlighted text.
- Use "add comment" tools to note which element and (if applicable) factor to which the highlighted section applies.
- For very large documents, provide only the necessary pages. The cover page and any other pages that provide necessary dates or version tracking must be included. NCQA strongly encourages that you use either scanned copies or Adobe PDF, which allows you to extract pages from large documents while retaining the integrity of the page layout.
- Name the document in a manner that helps the surveyor understand why it is relevant. The name should be as specific as possible.
  - Where possible, use a name the document as to the specific standard, element or factor(s) it supports. This may not be possible when the same document is being used for multiple standards/elements.
  - Alternatively, use a name that conveys what the document contains or means.

Both word processing programs (such as MS Word) and Adobe PDF support these features.

How Much Documentation is Enough…or Too Much?

Carefully read the information and explanation contained under each element in the Survey Tool, taking into account the data source(s) and the look-back period.

- Each element must have supporting documentation.
- If automatic credit is anticipated (i.e. for delegation to an NCQA-Accredited or Certified organization) please supply supporting documentation such as agreements or memoranda of understanding that demonstrates what functions the Accredited or Certified organization performs.
- If an element is not applicable to your organization, please supply supporting documentation or an explanation in the "Support text/Notes" box for the element. Except for file review and delegation elements that will be reviewed during the onsite visit, elements and factors should not be scored as not applicable (NA) in the Survey Tool without supporting explanation.

Documentation that is "supplementary in nature" may make the survey process more complex than desired. **Organizations should apply a philosophy of minimum necessary information when preparing documentation.**

Surveyors will always seek additional information when they do not find compliance in the documents presented.

Compliance Statements

A compliance statement is simply a concise statement of "how" your organization meets the requirements of the specific standard/element/factor. This statement helps the NCQA survey team to best understand the organization's processes and documentation within the context of the specific NCQA standard.

Methods for Including Compliance Statements

The following are two examples of methods that may be used:

1. Document the compliance statement in a word or PDF document and link it under the respective standard or element in the Survey Tool. You can prepare one document for each standard, addressing all the elements in the standard in that document. If this method is used, NCQA suggests that you name your statement of compliance specific to the standard and element that it supports (e.g. "Compliance Statement for QI 1") or use a name that conveys what the document contains.

2. Document the compliance statement in the support text/notes box underneath each respective element in the survey tool.

Format for a Compliance Statement

NCQA is not prescriptive regarding the format for the compliance statement; however, some general guidelines are provided below:

- Specify "how" the documentation supplied demonstrates compliance with the requirements of the standard or element. Because the organization is familiar with its own processes, it may seem apparent how documents demonstrate compliance within the context of the standard or element. However, the surveyor has limited familiarity with the organization's operational processes; and therefore, it's important to provide a foundation for how the documentation supplied meets the performance requirements of the specific element or factors.
- Compliance statements are especially helpful when more than one document is provided. If more than one document is necessary, provide information (in the ISS "Support Text/Notes" field or in a summary document, explaining how the documents relate to each other.
  - If the organization supplies numerous documents without an explanation, it is difficult for the surveyor to synthesize how the documents together may demonstrate compliance with the standard, element or factors.
  - Reference the key documents that demonstrate compliance with the specific standard, element and/or factors. Please remember to specify the document and specific pages or sections that evidence compliance.
- The statement of compliance does not have to be lengthy—just a concise statement of how the organization meets the specific requirements of the standard, element and/or factors.

A few examples are provided below for guidance only.

Example 1: Compliance Statement for UM 4, Element E (2011 HP Standards):

The organization has written procedures for using board-certified consultants and evidence that it uses these procedures to assist in making medical necessity determinations.

- Mountain Valley HMO has a written policy for the use of board-certified consultants. Please see document entitled **"UM Policy # 4312E: Use of Board Certified Consultant Reviewers."** Page 2 of the policy states that board certified consultants are used to make medical necessity decisions based on the unique needs of the specific case or as dictated by state regulatory requirements. Page 3 of the policy describes the actual procedures for using board certified consultants.
- Mountain Valley HMO maintains a list of board-certified consultants. Please see document entitled **"2011 Mountain Valley HMO Board Certified Consultant Reviewers."**
- Two blinded cases are provided to demonstrate board certified consultants are used in appropriate circumstances. Please see PDF files entitled: "Pediatric Cardiovascular Case Example" and **"TMJ Surgical Case Example."**

Key points about this example:

- The organization has addressed all key requirements of this element in the compliance statement.
- The organization addressed both data sources for this element: documented process and records or files. NCQA requires the organization to supply its written procedures and evidence of implementation (i.e. the explanation for this element specifies two example cases must be provided).
- The organization includes a list of board-certified consultants which is specifically noted in the explanation as a required document. Also of note, the "stem" of the standard statement specifies "written procedures" and "evidence of the use of the procedures."

Example 2: Compliance Statement for QI 3, Element A (2011 HP Standards)
Contracts with practitioners specifically require that:

1. Practitioners cooperate with QI activities.

2. The organization has access to practitioner medical records, to the extent permitted by state and federal law.

3. Practitioners maintain the confidentiality of member information and records.

- Mountain Valley HMO has a standardized practitioner contract that is used for both primary care physicians (PCPs) and specialty care physicians (SCPs). The standardized contract template contains the language specified in the three required factors of this element. Mountain Valley HMO has provided three executed PCP contracts and three executed SCP contracts for review. Please refer to the following PDF files that are linked to this element.
  - **Dr. Long PCP Example.**
  - **Dr. Smith PCP Example.**
  - **Dr. Thomas PCP Example.**
  - **Dr. Moore SCP Example.**
  - **Dr. Jones SCP Example.**
  - **Dr. Minturn SCP Example.**
- Each practitioner contract has been bookmarked and will automatically take the surveyor to the section of the contract that addresses the three required factors of this element. The applicable language has been highlighted in each contract.

Key points about this example:

- The organization has addressed all key requirements of this element in the compliance statement above.
- The organization provided the 6 contracts specified in the explanation: three active PCP and three active SCP.

contracts must be provided for review. Of note, if the organization had only provided contract "templates" it would not demonstrate full compliance with this element.

- The organization notified the surveyor that the documents are bookmarked and highlighted. This makes the review process more efficient for the surveyor when lengthy, detailed or numerous documents must be reviewed.

Are Compliance Statements Required?

The necessity of a compliance statement will vary based on the element and also on the degree to which the organization makes use of other tools (bookmarking, highlighting, and comments) to present a coherent story. The following are examples of two elements where the need for a compliance statement differs:

- RR 1, Element A (Member Rights and Responsibility Statement) requires either a copy of the Rights and Responsibilities statement or a policy and procedure describing the member's rights and responsibilities. Because these are very straightforward documents—and only one is document is required to demonstrate compliance—it may not be necessary for the organization to provide explanation because of the straightforwardness of the factors.
- QI 10, Element A (Continuity and Coordination of Medical Care—Opportunities for Improvement) requires the organization to demonstrate that it has analyzed data, identified opportunities and taken action for two different opportunities to improve coordination of care. This will likely require several documents for each of the two identified opportunities. Using a compliance statement, the organization can provide additional background on the activities, or "tell its story" and can explain how the multiple documents relate to each other and in what order they should be reviewed.

Bookmarking, effective highlight and comments can eliminate the need for a compliance statement for many elements.

Consumer Medication Information (CMI) Alignment to LTSS Standards Example

The screenshots below are an example of how the information provided in the CMI assessment align to the LTSS Standards and to which standards specific text applies. Note—examples have been taken from various parts of the document, and thus the screenshots do not create a complete document.

LTSS 3.A.4 START

Question 6: Type of Communication Assistance Required: Document the amount of assistance that the consumer requires for communication. If the consumer is unable to communicate, the CM/SC should check the response (box) entitled Unable to communicate. If the consumer can communicate without any assistance, the CM/SC is to check the response (box) entitled No assistance required. If the consumer requires language assistance the CM/SC is to check the response (box) entitled Language assistance. If the consumer requires mechanical assistance with communication, the CM/SC is to check the response (box) entitled Mechanical assistance. The response (box) entitled Language and mechanical assistance should be checked if the consumer requires both language and mechanical assistance with communication.

Use the Notes: clarify type of language assistance, ie interpreter, or mechanical assistance, ie. letter board

the consumer is being treated for the same. The assessor is to choose only one response (box).

The assessor is to document whether the consumer is currently being treated for each diagnosis or condition.

Not present = *The individual has not been diagnosed with a specific medical condition by a skilled medical professional.*

Present = *The individual has a specific diagnosis of a medical condition from a skilled medical professional and is currently being treated for that condition.*

Consumer reported = *The individual and/or supports indicate that the individual has a specific condition, but, the condition has not been formally diagnosed by a physician and/or is not currently being treated. Past medical history or condition can be documented as reported by the individual.*

LTSS 2.B.11

Question 3: Hearing Ability: Rate the consumer's hearing (while wearing his/her hearing appliance, if regularly used) as reported by consumer or indicated by any other source. . If the consumer's hearing is good, the CM/SC is to check the response (box) entitled Good. If the consumer's hearing is fair, check the response (box) entitled Fair. If the consumer's hearing is poor, check the response (box) entitled Poor. If the consumer is deaf, the CM/SC is to check the response (box) entitled Deaf. If the consumer uses a hearing aid to correct impaired hearing, the CM/SC is to check the response (box) entitled Uses hearing aid.

LTSS 2.B.5+6 START

2H: Cognitive and Mental Health Conditions

The purpose of this section is to gather and document the consumer's cognitive and mental health conditions.

The assessment questions and/or prompting questions included in this section do not include every condition or illness that a consumer may have been diagnosed with by his/her physician. The conditions or illnesses listed represent the more common or well-known diagnoses.

The assessor is to document in the notes section following each question any other diagnosed condition or illness. If the assessor does not know or has questions about where specific medical information should be documented, he/she must speak to the R.N. consultant and obtain further direction.

For questions 3, 4, and 5 of this section: If the consumer indicates that he/she was previously diagnosed with a traumatic brain injury (TBI), mental retardation (MR) or mental illness (MI) but is not being treated at this time, the assessor must document, in the notes sections, the type of treatment recommended and the reason that the consumer is not receiving treatment.

Questions 1 – 7

Question 1: Psychiatric Disorders: Determine whether or not the consumer has any type of psychiatric disorders/mental illness. Mental illness is defined as a mental or bodily condition marked primarily by sufficient disorganization of personality, mind, and emotions to seriously impair the normal psychological functioning of the individual. The illness may result in a disruption in a person's thinking, feeling, moods and ability to relate to others.

Question 6: Irreversible Conditions:

The purpose of this question is to determine if a consumer that is cognitively impaired has been medically evaluated to rule out that a reversible condition is not causing the impairment.

The assessor is to choose the Yes response (box) if the consumer is cognitively impaired and has been medically evaluated to determine if the cause of the impairment is reversible. If the resident has been medically evaluated, document that the evaluation occurred (yes) and explain the results of the evaluation in the notes section.

The assessor is to choose the No response (box) if the consumer is cognitively impaired, however the impairment has not been medically evaluated to ensure that he condition is not reversible.

LTSS 2.B.5+6
END

If the consumer is unaware if the impairment has been medically evaluated, the assessor is to choose the Unknown response (box).

NCQA Library Document Tracking

The full tracking document can be found in Appendix F.

CM Standard - Element	Document Name	File Path	Notes	Date Attached	Reference Pages	Relevance	Staff Responsible	Revisions Due
Not Linked	CM File Review Results.xls	CM File Review Results.xls.xlsm						
Not Linked	cred file review results.xls	cred file review results.xls.xlsm						
CM1 - A	HomeMeds JAGS Article	1 Vanderbilt RCT Meredith.pdf			All	Supporting		
CM1 - A	MSSP CM 1	2014-12-21 PICF CM 1.docx			All	Primary		
CM1 - A	MSSP CM 1Narrative	MSSP CM1 Narrative FINAL.docx			All	Primary	Marcia and Tahirah	
CM1 - A	MSSP Site Manual Chapter 3	MSSP Chapter_3.docx	Cross check page numbers		Sect. 3.100 p4; 3.110 p5; 3.130 p8; 3.140 p11; 3.150 p11	Secondary		
CM1 - A	MSSP Zip Code Lists	Zip Code List revised - South.doc	need to get revised lists (North, South, Kern and santa Barbara)		All	Secondary	Hugo	
CM1 - A	Partners Caregiver Programs	Partners Caregiver Broch 2014 7.pdf	Will remain, but need to ensure that it's up-to-date		All	Supporting	Check with Sherry	
CM1 - A	Partners MSSP Brochure	MSSP Broch 201	have updated brochure		All	Supporting	Communicatio	
CM1 - B	MSSP CM 1	2014-12-21 PICF CM 1.docx			1-2	Primary		
CM1 - B	MSSP CM 1 Program Narrative	MSSP CM1 Narrative FINAL.docx			5-7	Primary	Marcia and Tahirah	
CM1 - C	2014-05-15 Staff Meeting	22014-05-15 Staff Meeting.pdf	Need newer documentation on this; Finding Staff Meeting that addresses programs and content.		All	Secondary	Aloyce may have documents for South, Melissa has for North. Request agenda and documents from Supervisors meeting on Nov 17, 2015 where CCI is discussed.	

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Partners in Care Foundation

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[1] The SCAN Foundation is advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit www.TheSCANFoundation.org.

The John A. Hartford Foundation, based in New York City, is a private, nonpartisan philanthropy dedicated to improving the care of older adults. For more information, please visit www.jhartfound.org.

Appendix A. Program Description

Program Description for ABC CARE

ABC CARE Eligibility

ABC CARE enrolls all individuals who have been screened by the state as eligible for home-and community-based LTSS, and who opt to receive case management of their LTSS from ABC. The state determines eligibility through means testing and through assessment of functional limitations. Under current approved waiver, individuals are eligible for LTSS if they require moderate assistance with two or more activities of daily living (ADL), or if they require moderate assistance with one ADL and limited assistance with three or more ADLs or instrumental activities of daily living. Upon determination of eligibility for services, the state initiates enrollment into the CARE chosen by the individual. ABC CARE completes enrollment of all individuals who select to use our services, and who complete the enrollment process.

ABC CARE Services

ABC provides the following services to individuals enrolled in our [PROGRAM NAME]:

- Person-centered assessment
- Care planning
- Case management of HCBS, including meals delivery, personal attendant services, home health aide services, acquisition and maintenance of DME, home-delivered medication, incontinence supplies, health care-related transportation
- Transition support for enrolled individuals who have a short-term institutional stay (hospital or SNF) while enrolled in the program
- Referral to housing, congregate dining, non-health-care transportation, financial assistance and other community resources available, and for which the individual may qualify.

Evidence and Professional Standards

ABC CARE integrates the following evidence-based assessments into its assessment process:

Morse Fall Scale—http://www.networkofcare.org/library/Morse%20Fall%20Scale.pdf

Mini-Cog—http://geriatrics.uthscsa.edu/tools/MINICog.pdf

Self-Neglect—http://www.ncall.us/print/291

PHQ9—http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf

Columbia-Suicide Severity Rating Scale

- http://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf

Barthel Index of ADL—http://www.healthcare.uiowa.edu/igec/tools/function/barthelADLs.pdf

ABC CARE trains all case managers in the use of Motivational Interviewing and use of the trans-theoretical model in care planning.

Sources:

http://www.auburn.edu/academic/education/sences/classinfo/transtheortical.html
http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/BehavioralChangeTheories/BehavioralChangeTheories6.html
https://en.wikipedia.org/wiki/Transtheoretical_model#Stages_of_change

Miller, William and Rollnick, Stephen, Motivational Interviewing: Helping People Change. Third Edition. New York: Guilford Press, 2012. www.motivationalinterview.org

ABC CARE uses the Naylor Transition model to manage transitions.
http://www.nursing.upenn.edu/ncth/transitional-care-model/

The services ABC CARE provides are defined by the state (reference state contract). In addition, selection criteria for case managers, and specific training requirements for case managers and other agency staff who have client contact, are specified by the state. (reference state contract).

Program Goals

ABC CARE aims to improve the quality of life for all its clients. It seeks to provide person-centered services that specifically address client goals. Most clients desire to age in place, and remain in their homes. The following goals address our person-centered approach:

ABC CARE clients enrolled for 12 months or greater have 20% fewer hospital admissions in their first and subsequent years of enrollment than in the year prior to enrollment, and they spend 30% fewer days in skilled nursing facilities.

90% of ABC CARE clients answer "Always" or "Almost always" on an annual survey of whether their service plan reflects what is most important to them (see attached survey instrument).

Fewer than 15% of ABC CARE clients who are discharged from the hospital or SNF, are readmitted within 30 days.

Coordination of Services

ABC CARE coordinates closely with clients' primary care providers (PCP), specialists, as indicated, caregivers and LTSS service providers. In conducting the assessment, with consent from the client, ABC CARE reaches out to PCP and other medical providers, caregiver(s) and existing service providers, to seek input into the assessment (Reference assessment solicitation form). ABC CARE asks medical providers whether they wish to receive the entire service plan or a 1-page summary. With client consent, caregivers are invited to participate in service planning. Upon completion of the service plan, ABC CARE sends a copy of the full (or summary) service plan to the PCP. Case managers review the "Caregiver responsibilities" section of the service plan with the caregiver, seeks the caregiver's signature, and leaves a copy with the caregiver. Specific service orders are delivered to each service provider identified in the care plan. The care plan includes key telephone numbers, including the case manager's phone number and an emergency number, in case a service provider or caregiver is unable to perform a specified service. ABC CARE provides

written referrals to community resources. Written referrals are given to the client, and mailed to the community service provider of the client's choice, when possible. The case manager follows up by telephone with the client, and, if permitted by the client, with the community service provider, to track the status of referrals.

Partners in Care Community-Based Care Management/MSSP (2017) —Partners in Care Community-Based Care Management (CBCM) Program Description

Partners in Care Community-Based Care Management (CBCM) Program Description

Overview

The objective of community-based care management (CBCM) is to avoid premature placement in nursing facilities while fostering independent living in the community; avoiding inappropriate use of hospital and emergency department care, and maintaining functioning to the extent possible given patients' age and health conditions. Partners in Care Foundation *(Partners)* has CBCM programs of various levels of intensity and duration for different populations, using custom-designed targeting criteria for each. In general, *Partners'* programs address self-care, behavioral health, functional, and social issues for adults with chronic physical, cognitive or emotional conditions who are at moderate to high risk for use of facility-based care (hospital, emergency department, nursing facility). Beyond care management itself, typical services which *Partners* provides patients, through referral or purchase, can include door-through-door assisted transportation (including companion for doctors' visits, if needed), respite care, home modifications to ensure safety and accessibility, emergency utility payments, replacement of furniture & equipment needed to stay safe and independent (including appliances), home-delivered meals, emergency response system, medication management devices and services, supplementary personal assistance, housekeeper or chore service, in-home therapy – in essence, anything required to keep a safe, healthful and secure environment and to keep individuals in their homes at the highest level of functioning, health and independence possible.[1]

The program *Partners* is putting forward for NCQA case management accreditation is the Multipurpose Senior Services Program (MSSP), because it is our most mature and comprehensive CM program and contains elements of all the other key programs. MSSP is a state-regulated program provided under a federal Medicaid waiver. MSSP provides community-based care management services to eligible Medicaid beneficiaries enabling them to remain in or return safely to their homes. More recently it also covers Dual Eligibles under the state demonstration. Program-wide services must be provided at a cost lower than that for nursing home placement[2]. Every aspect of MSSP is well specified in the California Department of Aging's (CDA) MSSP Site Manual, last published in May 2012 and updated as deemed necessary by CDA.

Care Management is the cornerstone of MSSP. It involves the coordination of existing community resources that provide the services required to enable patients to continue living at home. MSSP care management includes individual assessment, collaborative care/service planning, service arrangement/purchasing and patient monitoring. A care management team consisting of a social service professional and a registered nurse (RN) evaluates each patient, commencing with a complete health and psychosocial assessment to determine the services needed. The team then works with the patient and family to develop an individualized care plan. When arranging services the assigned primary care manager (PCM) first explores informal support that might be available through family, friends and volunteers. The PCM then seeks existing publicly funded services and ensures that service arrangements are completed. If needed services are not available through informal supports and community programs, the care management team can authorize the purchase of waiver-specified services from program funds[3].

CM1, Element A. Evidence used to develop the program

[1] *Partners'* MSSP Brochure English; MSSP Brochure Spanish
[2] MSSP Site Manual, Ch. 1, Section 1.000, p. 1
[3] Ibid, 1.300, p. 1-3

CM1: Program Description & Evidence Base – Partners in Care Community-Based Care Management/MSSP; 4/18/2017; p. 1/8

Evidence used to develop the program is based primarily on the regulations promulgated by the California Department of Health Care Services and the California Department of Aging based on the state's 1915(c) Medicaid Home and Community-based Services Waiver as approved by CMS every five years since 1987. MSSP relies on federal and state authorities to provide evidence-based guidelines for the program. The specific program authorities cited include[4]:

1. Federal Social Security Act, Title XXI (Medicaid), Section 1915(c).
2. Code of Federal Regulations, Title 42, Volume 3, Chapter IV, Section 440.180.
3. California Welfare and Institutions Code 14132(t).
4. CMS Home and Community-Based Services Waiver #0141.R04.00
5. California Department of Aging Standard Agreement (Site Contract).
6. California Code of Regulations, Division 3, Chapter 3, Article 4, Section 51346.
7. Interagency Agreement between California Department of Health Care Services and California Department of Aging.

In addition, an evidence-based subcomponent of the MSSP assessment is the Short Portable Mental Status Questionnaire (SPMSQ)[5]. Within *Partners'* MSSP, mental state is assessed using the Geriatric Depression Scale.[6,7]

Additional authority is drawn from the HomeMeds℠ medication safety intervention[8], approved by the US Administration for Community Living as a highest level evidence based program and included in their Aging & Disability Evidence-based Programs and Practices national registry[9] and the Agency for Healthcare Research & Quality's Innovation Exchange with a strong evidence rating[10].

Other evidence-based short-term post-hospital care transitions programs used by *Partners* include Dr. Eric Coleman's Care Transitions Intervention[11] and the Bridge telephonic social work intervention from the Rush University Medical Center.

CM1, Element A-1 Criteria for identifying patients who are eligible for the program.

The MSSP eligibility criteria[12] include all of the following, explained in greater detail below:

- Certifiable for placement in a nursing facility (NF) per California Code of Regulations, Title 22, Sections 51334 and 51335
- Age 65 or older.
- Receiving Medi-Cal *(California's name for its Medicaid program)* under an appropriate aid code.
- Able to be served within MSSP's cost limitations.

[4] MSSP Site Manual, Ch. 1, References Section
[5] Pfeiffer E. A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. J Am Geriatr Soc. 1975;23(10):433-41.
[6] Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale: a preliminary report. J Psychiatr Res. 1982-83;17(1):37-49.
[7] Sheikh JI, Yesavage JA. Geriatric Depression Scale (GDS): recent evidence and development of a shorter version. Clin Gerontol. 1986 June;5(1/2):165-173.
[8] Homemeds JAGS RCT Article: Meredith S., Feldman P. and Frey D., "Improving Medication Use in Home Health Care Patients: A Randomized Controlled Trial". Journal of the American Geriatrics Society, 50:1481-1491, 2002. *Uploaded.*
[9] http://www.acl.gov/Programs/CDAP/OPE/ADEPP.aspx
[10] https://innovations.ahrq.gov/profiles/care-managers-use-software-aided-medication-review-protocol-frail-community-dwelling
[11] Coleman EA, Parry C, Chalmers S, Min SJ. Arch Intern Med. 2006;166:1822-1828.
[12] MSSP Site Manual, Chapter 3, 3.100, p. 4

- Appropriate for care management services.

Level of Care Determination[13]***:*** An individual Level of Care (LOC) evaluation is made by a nurse care manager (NCM) for each eligible applicant. LOC determinations are based on the nurse's professional assessment and observations and/or information gathered through the screening tool and other sources such as care management staff, the patient, family, attending physician and others involved in caring for the patient. The information required for this analysis may be obtained by conducting a home visit, by a record review, or by a combination of both activities.

The applicant must be certified as functionally impaired or have a medical condition to the extent of requiring the LOC provided in a nursing facility (NF) according to CA Title 22, Division 5, relating to nursing facilities. The Title 22 criteria were developed specifically for NF eligibility, thus, applying these criteria to determine LOC for individuals living in the community can be challenging. To make this translation from facility-focused to community-based or "patient-focused" care, the NCM must focus their analyses and judgment on the following elements:

- Cognition and/or Sensory deficits.
- Activities of Daily Living (ADLs).
- Instrumental Activities of Daily Living (IADLs).
- Other/Environment (e.g., bed-bound or patient who cannot be safely left alone).

Aid Code[14]***:*** In order to be eligible for MSSP, the patient must have a qualifying primary Medi-Cal aid code. Qualifying primary Medi-Cal aid codes are: 1D, 2D, 6D, 1E, 2E, 6E, 1X, 1Y, 10, 14, 16, 1H, 20, 24, 26, 60, 64, 66, and 6H.

Living in the contracted service area[15]***:*** ZIP Codes for patient residences should be within the geographic boundaries defined in the site's contract. Requests to change a site's contracted service area must be approved by CDA prior to serving patients outside the contracted service area. *Partners'* MSSP program operates in the areas of South Los Angeles (e.g., Compton, Watts, Lynwood), in the northeast San Fernando Valley, Santa Clarita Valley and Antelope Valley areas of Los Angeles County, and in Kern County (e.g., Bakersfield). A zip-code list is available upon request.

Able to Be Served within MSSP's Cost Limitation[16]**.** The average monthly cost for all Medicaid services cannot exceed 95% of the average monthly cost of institutional care (Section 3.920, Benchmark and Appendix 33). During the screening process, if ongoing costs are projected to exceed the cost of institutional care (100% of the Benchmark), the applicant is ruled ineligible for MSSP. However, if there is a definite plan to bring these costs down to the Benchmark within three months, the applicant may still be enrolled.

[13] Ibid, 3.110, p. 8
[14] Ibid, 3.130, p. 11
[15] Ibid, 3.140, p. 11
[16] MSSP Site Manual, Chapter 3, 3.150, p. 11

Appropriate for Care Management Services[17]: This criterion addresses the patient's need for and ability/willingness to participate in the care management process. Both elements must be present.

- "Need for care management" is indicated when a patient requires assistance to: gain access to community services; maintain or effectively utilize available services; and/or manage serious health conditions.
- "Ability/willingness to participate" is indicated by the patient's cooperation in formulating and then carrying out the care plan.

Note: The term "patient" includes a patient's Personal Representative when the patient is cognitively unable to participate independently.

Partners confirms and documents new patients' perceptions of why they were referred to the program, including their perceived needs and their goals. This can occur during the screening &/or the assessment process. Differences in perceptions between the referral source, the patient, and the care manager must be identified, acknowledged and addressed in the initial assessments. Changes in these issues should be acknowledged and recorded in the progress notes.

CM1, Element A-2 Services offered to patients.

In all cases *Partners* will exhaust services available at no charge before approving waiver-paid services, which will be deployed to fulfill needs identified through the comprehensive assessment and which meet the criteria of allowing the patient to remain at home safely and function at her/his highest possible level of independence. MSSP provides these services for patients, as determined by the assessment and care planning process[18],[19].

- care management
- respite care
- supplemental personal care
- adult day care
- adult day support center
- HomeMeds/medication management support or devices
- Supplemental DME
- communication
- housing assistance
- nutritional services
- protective services
- purchased care management
- supplemental chore
- supplemental health care
- supplemental personal care assistance
- supplemental protective supervision
- transportation for individuals ages 65.

Within MSSP, the care management process involves:

- Understanding the Waiver and other resources (community, Medicare, Medi-Cal State Plan, Older Americans Act Title III, etc.).
- Conducting and documenting timely and comprehensive assessments and reassessments.
- Developing and updating a care plan and tracking outcomes.
- Coordinating services and/or purchases using waiver funds only for approved expenditures after other resources have been exhausted or are not available.
- Monitoring interventions and the impact on functional abilities and goals.
- Documenting and record keeping.

[17] Ibid, 3.160, p. 11
[18] Comprehensive Service List
[19] Partners LTSS Services Brochure

- Terminating participation in the program when eligibility is lost (e.g., patient moves out of area, no longer qualifies for Medi-Cal, or improves in condition such that services are no longer needed).

The Patient's primary point of contact for the duration of their participation in the program is their care manager (CM). Care management is a cooperative collaboration of patient, family (as appropriate) and care manager.

With the exception of pre-screening, other care management activities (assessments, reassessments and quarterly visits) must be conducted at the patient's residence[20].

CM1, Element A-3 Defined program goals.

Program goals for MSSP include the following:

a. Minimize rate of permanent nursing home placement
   i. Specific target is not more than 10% of patients placed in nursing homes in any year.
b. Minimize 30-day hospital readmission rate
   i. Specific target is 10%
c. Achieve a 90% "very good" patient rating of care plan manager
d. Achieve a 90% "always" rating for each element of the MSSP staff rating (e.g., courteous, respectful, helpful…)
e. Maintain census at 95%-105% of state or health plan-approved level
f. Maintain care management staffing ratio at 40:1 or better.
g. Peer review rates 95% of sampled cases rated at 4 or 5 on 5-point scale
h. 90% of patient complaints resolved within 5 days
i. 90% of vendor issues resolved within 5 days
j. 90% of initial assessments are completed within 2 weeks after enrollment
k. 90% of care plans are completed within 2 weeks after assessment

CM1, Element B. Partners in Care Foundation reviews the evidence base for its community-based care management programs at least annually.

CM1, Element B-1 A systematic review of evidence used to develop the program.

Partners reviews evidence related to its programs on an ongoing basis by monitoring appropriate publications, websites, and membership organizations for new research findings and best practices and attend local, state, and national conferences to learn new approaches. *Partners* and/or staff maintain journal subscriptions and memberships in a number of organizations to enable easy access , including:

- American Society on Aging
- Gerontological Society of America

[20] MSSP Site Manual, Chapter 3, 3.610, p. 16

- National Association of Area Agencies on Aging
- Evidence-Based Leadership Council
- National Association of Social Workers
- American Public Health Association
- Home Health Care Quarterly
- Health Affairs
- JAMA
- New England Journal of Medicine

Importantly, *Partners* maintains close working relationships with the primary source of evidence-based programs and practices designation in the field: the US Administration for Community Living.

CM1, Element B-2 A systematic review of evidence (including clinical or technical literature or government research sources) by at least two appropriate practitioners.

At least two appropriate community-based social service practitioners are involved in an annual review of evidence. With regard to *Partners'* CBCM program, "appropriate practitioners" refers to licensed &/or Master's-prepared social workers, registered nurses and/or others who have specialized training and experience related to patient engagement, community-based care management and deployment of resources to enable older, chronically ill and disabled adults to remain at home and in their communities safely and as independently as possible, with optimal health.

1. In addition to regulations relating to the MSSP program, the agreed-upon sources of evidence used by *Partners* for its community-based care management program include:
   a. Materials published by entities of the U.S. and California state governments, e.g., CDC *Check for Safety: A Home Fall Prevention Checklist for Older Adults*
   b. Textbooks in current use by schools of social work, nursing, or gerontology.
   c. Material promulgated by key national organizations addressing the needs of a particular population, e.g., Alzheimer's Association or Arthritis Foundation.
   d. Standards and training materials published by universities and national professional associations, e.g., National Association of Social Workers (http://www.socialworkers.org/practice/standards/NASWFamilyCaregiverStandards.pdf)
2. *Partners* will hold meetings of the Community-Based Care Management (CBCM) Evidence Review Committee (ERC) at least annually. The ERC will consist of at least one each of the following licensed staff or consultants: LCSW, RN, and pharmacist, with other licensed professionals (e.g., dietitian) participating as needed. To the extent possible, the committee will seek input from a doctoral-level professional familiar with the literature relating to assessment of and service response to needs brought about by aging, disability, cognitive impairment, or chronic disease. Professionals with expertise in culturally competent social services for these populations will also be included as needed and available.
3. *Partners* will maintain documentation of all reviews and recommendations for changes made by the ERC. Hard copies of sign-in sheets and documents are kept in the executive offices. Electronic copies will be kept in a team SharePoint site. This site will include articles reviewed and minutes for all meetings.

4. Outcomes of and any recommendations resulting from the ERC's reviews will be reported at least annually to *Partners'* Policy and Procedure Development and Management Committee and reflected in the minutes as appropriate.

CM1, Element C. Program Content Consistent with Evidence

CM1, Element C-1. Reviewed program content against evidence used to develop the program.

For MSSP, all primary evidence comes from state regulations, which flow from the terms of the CMS-approved waiver. Both the California Department of Aging and the California Department of Health Care Services perform regular surveys to ensure high quality service delivery and conformance with regulations. Recent surveys have had no material findings and no requirement for corrective action plan.

CM1, Element C-2. Assessed whether patient materials are consistent with current evidence, and if they are not, that it took action to make them consistent.

All materials handed out to participants are reviewed for consistency with current evidence. For MSSP this means that they meet the criteria listed in CM1, B2-1. Handouts used for MSSP include:

- State-mandated forms, program explanations, rights and responsibilities, etc. available in the appendices of the MSSP site manual[21].
- Current advance directive forms[22]
- Information about emergency-response call systems (about 80% of clients receive this service)
- Information about caregiver support[23]

CM1, Element C-3. Assessed whether staff training materials are consistent with current evidence, and if they are not, that took action to make them consistent.

The primary training for MSSP staff comes directly from the California Department of Aging. They provide three training modules:

1. Overview of MSSP
2. Eligibility Assessment
3. Care Planning and Coordination

HIPAA training is required of all staff with access to protected health information, including program and administrative assistants. In 2014, *Partners* completed a security audit and self-assessment through The Vantage Group, an information security consulting firm (http://www.vantage-grp.com/about-us/). Vantage Group provides a self-paced course for all staff and keeps content up to date and in sync with federal and state law and guidelines. These tools, called TrustWave, are accessed through https://sae.trustwave.com/

[21] http://www.aging.ca.gov/programsproviders/mssp/SiteManual/MSSP_Manual_2012_Appendices.aspx
[22] Partners' Patient Handouts
[23] Partners' Caregiver Programs

Diversity training is based on the US Health Resources and Services Administration's "Effective Communication Tools for Healthcare Professionals: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency" tools. This is a well-documented curriculum based on peer-reviewed research with appropriate citations and references provided. It is accessed through the Public Health Foundation's TrainNational website: www.train.org.

Specialty training is secured from authoritative sources such as the local chapter of the Alzheimer's Association or the local Caregiver Resource Center.

CM1, Element C-4. Reviewed program content for cultural and linguistic appropriateness.

All materials are available in English and Spanish. We hire staff with backgrounds and language capabilities to address other major cultural groups in the service area – namely Chinese (Mandarin & Cantonese), Filipino, Russian, Farsi and Armenian. For other language groups we draw on a language line to assist with minority languages. We also engage family members and other caregivers to assist with translation and cultural sensitivity when they are the best resource.

MSSP Site Directors determine appropriate staffing based on current and anticipated cultural, ethnic and linguistic characteristics of the patient populations for each site. An example of this cultural matching approach relates to Russian immigrants, who often best resource.
Identify cases where we have health issues related to poor environmental conditions, even cancers related to nuclear plant leaks. By retaining care managers familiar with both the language and the country, we can more easily discover and meet patients' needs.

Aging & In-Home Services of Northeast Indiana, Inc. (2017)—Case Management Department

CASE MANAGEMENT PROGRAM DESCRIPTION

MISSION: We are professional advocates for older adults, persons with disabilities and their caregivers, coordinating services which maximize dignity and independence, focusing on the whole person.

I. Eligibility Criteria

a. Case Management

- Individuals must meet both financial and Medicaid eligibility requirements
- To be medically eligible for the waiver program, an individual must meet the required "Level of Care." Level of Care is the minimum need an individual must have to be considered eligible for the waiver, and represents the compilation of medical, professional nursing and non-professional nursing-related needs of an individual based on an assessment of the individual's medical needs, physical, mental and cognitive abilities to ensure the health, safety and well-being of the individual. For the Aged and Disabled or the Traumatic Brain Injury Waivers, a person must be deficient in three Activities of Daily Living(ADLs) or have a skilled need.
- The Level of Care is determined by Aging & In-Home Services and the Division of Aging based upon the InterRAI assessment and physician's recommendation of home and community-based services, through the 450B form. The case manager will submit this form to the client's primary care physician for completion. The waiver case manager will complete an annual Level of Care evaluation for waiver services.

II. Services

The Aging & In-Home Services Case Management department provides person-centered case management to eligible clients. Case Managers work with each client to identify their goals of care and present options and services to the client. The following options are services offered through the funding programs and are available to clients when developing their care plan. The providers of these services are contracted with Aging & In-Home Services, and the services are not provided by Aging & In-Home Services.

a. Adult Day Service

b. Attendant Care

c. Homemaker

d. Respite

e. Assisted Living

f. Environmental Modifications

g. Health Care Coordination

h. Home Delivered Meals

i. Nutritional Supplements

j. Personal Emergency Response Systems

k. Pest Control

l. Specialized Medical Equipment and Supplies

m. Transportation

n. Vehicle Modifications

III. Case Management Service Definition

a. Case Management is defined in Indiana Code (455 IAC 1.2-4-10) as comprehensive services comprised of, but not limited to, the following:

- Assessment of an individual to determine the individual's
  - Functional impairment level; and
  - Corresponding need for services.
- Development of a person centered care plan addressing an eligible individual's needs.
- Supervision of the implementation of appropriate and available services for an eligible individual.
- Advocacy on behalf of an eligible individual's interests.
- Monitoring the quality of community and home care services provided to an eligible individual.
- Reassessment of the care plan to determine the continuing need and effectiveness of the community and home care services provided to an eligible individual.
- Provision of information and referral services to individuals in need of community and home care services.

Indiana Administrative Code, Article 2 Home and Community Based Services, Rule 4

IV. Professional Standards

a. Evidence and Professional Standards

The operating procedures Aging & In-Home Services Case Management rests on a combination of professional standards, from the Indiana Department of Aging and professional organizations related to the field of aging and disability service delivery. The scope for service provision and code of ethics for appropriate service delivery is dictated by the Indiana Administrative Code. The Case Management department also relies on professional sources for evidenced based practices in case management, including: the Administration for Community Living (ACL), American Society on Aging (ASA), the National Association of Social Workers (NASW), National

Association of States United for Aging and Disability (NASUAD), Leading Age, The John A. Hartford Foundation, The SCAN Foundation and the National Core Indicators (NCI).

b. Code of Ethics

1. Provide professional services with objectivity and with respect for the independence and the unique needs and values of the individual being provided services.
2. Avoid discrimination on the basis of factors that are irrelevant to the provision of services, including, but not limited to, the following:
   - Race.
   - Creed.
   - Gender.
   - Age.
   - Disability.
3. Provide sufficient objective information to enable an individual or the individual's guardian to make informed decisions.
4. Accurately present the following:
   - Professional qualifications and credentials.
   - Professional qualifications of all employees or agents.
5. Require all employees or agents to assume responsibility and accountability for personal and professional competence in the following:
   - The practice of the person's profession.
   - The provision of services under this article.
6. Require professional, licensed, or accredited employees or agents to adhere to acceptable standards for the employee's or agent's area of professional practice.
7. Require employees or agents to comply with all laws and regulations governing a licensed or accredited professional's profession.
8. Require all employees or agents to do the following:
   - Maintain the confidentiality of individual information consistent with the standards of this article and all other laws and regulations governing confidentiality of individual information.
   - Conduct all practice with honesty, integrity, and fairness.
   - Fulfill professional commitments in good faith.
   - Inform the public and colleagues of services only by use of factual information.

9. Refrain from the following:
    - Advertising or marketing services in a misleading manner.
    - Engaging in uninvited solicitation of potential clients who are vulnerable to undue influence, manipulation, or coercion.

10. Make reasonable efforts to avoid bias in any kind of professional evaluation.

11. Notify the appropriate party, which may include:
    - DDARS.
    - the Indiana state department of health.
    - a licensing authority; (D) an accrediting agency.
    - an employer.
    - the office of the attorney general, division of consumer protection; of any unprofessional conduct that may jeopardize an individual's safety or influence the individual or individual's representative in any decision making process.

Division of Aging; 455 IAC 2-21-1

V. Program Goals

Assessments

95% of clients will have documentation of a comprehensive assessment within 90 days or annually.

Care Plans

95% of clients will have documentation of a comprehensive LTSS care plan annually.

Shared Care Plan

100% of client care plans will be transmitted to key long term services and supports providers within 30 days of development or update.

Client Satisfaction

90% of clients will report satisfaction with services/interactions they received.

Advanced Care Planning

Educate consumers and their families/caregivers on advanced care planning matters (95% of clients).

Fall Prevention

95% of clients will have a future fall risk assessment in their annual review.

VI. Care Coordination

Care Planning: The Case Manager is responsible for creating a plan of care for the individual that:

1. Consists of a formal description of goals, objectives and strategies, including the following:
   - Desired outcomes.
   - Persons responsible for implementation.
2. Is designed to enhance independence.
   a. The case manager will assess the appropriateness of an individual's care plan and goals at least once every ninety days.
   b. All entities responsible for providing service to an individual will do the following:
      i. Coordinate the services provided to an individual.
      ii. Share documentation regarding the individual's well-being, as required by the individual's care plan.

Care Coordination: Reviewing the quality and adequacy of services and improving coordination is imperative to good case management practice. Based on a client's preferences, the care plan will include evidence of frequency, amount and duration of service, as well as who will provide the service(s). Clients choose their own providers, and providers receive notification of when service is to be delivered.

The Case Manager will contact the service provider(s) included in the client's care on a regular basis, depending on the services delivered and the needs of the client, but not less frequently than 30 days for an initial case and every 90 days thereafter. During these follow-ups, the case manager will discuss any health changes, needs, goals of care and other pertinent information important for care delivery. The 'Physician Follow-up" form is available as a mechanism to share health changes and other concerns with the client's primary physician. Critical Incidents are reported through the online reporting software, and notifications are provided to the service providers if appropriate.

The Case Manager will document all contacts with service providers within the electronic documentation system.

Precaution will be made to protect the confidentiality of client information. Individual informed client consent must be obtained before any client information is shared with another agency except in the clearly documented case of client emergency. Only necessary information must be communicated to agencies involved in the care plan.

Developed 11/22/16, revised 1/31/17

County of San Diego Aging and Independence Services (n.d.)—Live Well Care Connections

Name & Identification

Client Name:

Family present:

Personal Information

Assessment Date:

Gender:

DOB:

Address:

Marital Status

Language:

Responsibility / Advanced Directive:

Emergency Contact:

FINANCIAL AND LEGAL	HAS	NEED
SSDI		
SSA		
SSI		
VETERANS BENEFITS		
RETIREMENT		
POA Financial		
POA Medical		
Advanced Health Care Directive		

****If NEED, provide community referals**

HEALTH INSURANCE			
MEDI-CAL	Yes	No	ID #
MEDI-CAL HMO	Yes	No	ID #
CAL MEDICONNECT	Yes	No	ID #
MEDICARE A & B	Yes	No	ID #
MEDICARE HMO	Yes	No	ID #
OTHER HEALTH PLAN	Yes	No	ID #
NOT INSURED	Yes	No	

References:

Barthel Index of ADL - http://www.healthcare.uiowa.edu/igec/tools/function/barthelADLs.pdf

Morse Fall Scale - http://www.networkofcare.org/library/Morse%20Fall%20Scale.pdf

Mini-Cog - http://geriatrics.uthscsa.edu/tools/MINICog.pdf

Self-Neglect - http://www.ncall.us/print/291

PH9 - http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf

Columbia-Suicide Severity Rating Scale
- http://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf

Reason for Assessment

Type of Assessment
1. Initial Assessment:
2. Follow-up Assessment:
3. Routine assessment at fixed interval:
4. Change of Condition:
5. Review at return from hospital:
6. Other

Case Manager (RN/SW)

1.
2.
3.

Are there any financial difficulties

Problematic Expenses	Yes	No
Excess Spending	Yes	No
Unable to afford food most months	Yes	No
Difficulty managing own finances	Yes	No
Unable to afford medications	Yes	No
Unable to afford SOC or Insurance Premiums	Yes	No
Other	Yes	No

Medical Providers	**Contact Info.**
Primary Care Physician:	
Cardiology:	
Other:	
Other:	
Other:	
Pharmacy:	
Address:	

Live Well Care Connections Appendix Page 11

Vitals

Blood Pressure _____
Pulse _____
Respiration _____
Temperature (option) _____
O2 Sat (option) _____
Height _____
Weight _____

Health Conditions / Preventative Health Measures

Influenza vaccination	If yes, date:	_____
Pneumonia vaccination	If yes, date:	_____

Health Problems

Diarrhea	Y	N
Constipation (no BM 3days)	Y	N
Loss of appetite	Y	N
Urinary frequency / urgency 3x/nightly	Y	N
Fever	Y	N
Vomiting	Y	N
Edema	Y	N
Dizziness	Y	N
Chest pain	Y	N
SOB	Y	N
Pain (Type, Location, Pattern, Quality descriptive, tx)	Y	N

**If Yes, assess need for intervention/referral

Drinking / Smoking

Do you smoke?	Y	N

**If Yes, assess need for referral

Do you drink?	Y	N

How much per day? _____
**If Yes, assess need for referral _____

FALL

Have you fallen in the last six months?	Y	N

Reason for fall? _____
How many times have you fallen in the last six months? ☐
If Yes, Refer to Fall Prevention Program

Live Well Care Connections Appendix Page 12

List of All Medications **Allergies:** _____

Medication	Dose	Time Taken				Reason

Live Well Care Connections Appendix Page 14

Vision

Problem with vision	Y	N
Wears glasses	Y	N

Last assessment: _____

VISION DECLINE

Noted vision decline since last assessment	Y	N

If **Yes**, assess need for refferal

_____

Communication / Hearing

HEARING

Problem with hearing	Y	N
Wears a hearing aid	Y	N

EXPRESSION

Problem expressing ideas	Y	N
Trouble in completing a sentence or finding words	Y	N

COMPREHENSION

Problem understanding a conversation	Y	N
Omits some or part of the message	Y	N
Still able to understand most of the conversation	Y	N

COMMUNICATION DECLINE

Noted communication decline since last assessment	Y	N

Dental

Do you wear dentures?	Y	N
Does the client able to eat his/her food without difficulty	Y	N

If No, assess need for refferal

_____

Comments:

_____

_____

_____

Live Well Care Connections Appendix Page 15

Cognitive (SW/RN)

MINI-COG

1. Instruct the patient to listen carefully and repeat:

APPLE	WATCH	PENNY
MANZANA	RELOJ	PESETA

2. Administer the Clock Drawing Test

3. Ask the patient to repeat the three word given previously

1. 2. 3.

Score:

0 **Positive** for cognitive impairment
1-2 **Abnormal** CDT then positive for cognitive impairment
1-2 **Normal** CDT then negative for cognitive impairment
3 **Negative** screen for dementia (no need to score CDT)

Nutritional / Hydration

Weight

Diet:

Has the client lost or gained weight in the last six months? Y N
If Yes, Refer Dietitian/Nutritionist

How many drinks of water/beverages do you drink daily?

How many meals do you eat a day?

Has the client lost or gained weight in the last six months?

Comments

Live Well Care Connections Appendix Page 16

Physical Function (SW/RN)

Bowels
0 = incontinent (or needs to be given enemata)
1 = occasional accident (once/week)
2 = continent
Patient's Score: ☐

Bladder
0 = incontinent, or catheterized and unable to manage
1 = occasional accident (max. once per 24 hours)
2 = continent (for over 7 days)
Patient's Score: ☐

Grooming
0 = needs help with personal care
1 = independent face/hair/teeth/shaving (implements provided)
Patient's Score: ☐

Toilet use
0 = dependent
1 = needs some help, but can do something alone
2 = independent (on and off, dressing, wiping)
Patient's Score: ☐

Feeding
0 = unable
1 = needs help cutting, spreading butter, etc.
2 = independent (food provided within reach)
Patient's Score: ☐

Transfer
0 = unable – no sitting balance
1 = major help (one or two people, physical), can sit
2 = minor help (verbal or physical)
3 = independent
Patient's Score: ☐

Mobility
0 = immobile
1 = wheelchair independent, including corners, etc.
2 = walks with help of one person (verbal or physical)
3 = independent (but may use any aid, e.g., stick)
Patient's Score: ☐

Dressing

Live Well Care Connections Appendix Page 17

0 = dependent
1 = needs help, but can do about half unaided
2 = independent (including buttons, zips, laces, etc.)
Patient's Score: [ ]

Stairs
0 = unable
1 = needs help (verbal, physical, carrying aid)
2 = independent up and down
Patient's Score: [ ]

Bathing
0 = dependent
1 = independent (or in shower)
Patient's Score: [ ]

Total Score: [0]

Live Well Care Connections Appendix Page 18

Psychological Function (SW/RN)

Anxiety	none	some	severe
Combative, Abusive, Hostile Behavior	none	some	severe
Depression	none	some	severe
Delusions/Hallucinations	none	some	severe
Wandering	none	some	severe
Paranoid Thinking / Suspiciousness	none	some	severe
Suicidal	none	some	severe
Alzheimer's Disease/Other related Dementias	none	some	severe
Resists Care	none	some	severe
Other (Grief/Substance Abuse)	none	some	severe

Noted change in Pyschologic Function since last assessment	Y	N
**If Yes, Do you need to refer to Mental Health?	Y	N
Evidence or Indication of Abuse, Neglect, or Exploitation	Y	N

**If Yes, Complete ESNA & Report to APS:___/___/___

Perform Elder Self Neglect Indicator (ESN Score:) ☐

Social Function (SW)

Do you feel good spending time with acquintances, friends, and families?	Y	N
Are you able to express frustration, concern, anger to family or friends?	Y	N
Do you participate in social, religious, occupational, or preferred activities?	Y	N

How long do you spend time alone? ☐

1. Never
2. An hour
3. 4 hours or longer
4. All the time

Do you feel lonely or sad?	Y	N
Has client experienced any significant events or changes in the last year?	Y	N

Describe:

_____

_____

Current activites/hobbies?

_____

_____

Referral for emotional support?	Y	N
Referral for socialization?	Y	N

Referrals:

_____

_____

Live Well Care Connections Appendix Page 19

Informal and/or Formal Support

Name Helper/Caregiver	Relationship
1.	
2.	

Does Helper live with client? Y N
Does client have other forms of support? Y N
Explain :

What type of help do you need?	ADLs	IADLS

How many hours of caregiving does client receive in 24 hour?

Caregiver Status

Primary caregiver able to adequately provide support? Y N
Primary caregiver express burnout, distress, difficulty with his/her role? Y N
Primary caregiver no longer able to provide support? Y N

Does caregiver now need extra support for her or his self? Y N
Explain:

Live Well Care Connections Appendix Page 20

Identification of barriers

Make an "X" next to identified barrier presented:

Individual's lack of desire to participate in the case management plan.	☐
Lack of availability of informal supports.	☐
Individual's belief that participation will not improve health or quality of life.	☐
Cultural or spiritual beliefs.	☐
Financial, insurance or transportation limitations that may hinder participation in care.	☐
Individual's mental and physical capacity to participate in care.	☐
Individual's lack of understanding of a condition.	☐
Individual's hearing or communication impairment.	☐
Other	☐

If "X" is marked, explain:

Client Problem List:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Goals:

_____

_____

Client's goals prioritized:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Live Well Care Connections Appendix Page 21

Environmental Assessment

Any problems related to client's living arrangements?	Yes	No
Lives Alone	Yes	No

Check any of the following which are problems:

O Loose rugs	O Inadequate kitchen facilities
O Electrical cords	O Inadequate bathroom facilities
O Cluttered house	O Inadequate heating
O Unclean house	O Inadequate cooling
O Unsafe stairs	O Phone accessibility
O Other	O Weapons
Comments:	O Pets

Environmental Safety Special Equipment:

Tub	Yes	No
Shower	Yes	No
Hand-held shower	Yes	No
Bath bench	Yes	No
Grab bars: toilet	Yes	No
Grab bars: shower	Yes	No
Grab bars: tub	Yes	No
Raised toilet seat	Yes	No
Emergency response system	Yes	No
Smoke alarm	Yes	No

Comment:

Assistive Devises Used by Client:

Cane	Yes	No
Walker	Yes	No
Rolator	Yes	No
Wheelchair: Manual	Yes	No
Wheelchair: Power	Yes	No
Scooter	Yes	No
Hoyer Lift	Yes	No
Other	Yes	No

Comment:

Live Well Care Connections Appendix Page 22

Review of Evidence and Professional Standards for NCQAHealth

The evidence-based guidelines and program content used by the NCQAHealth Long-Term Case Management Program (LTCMP) are based on the Case Management Society of America's (CMSA) Practice Guidelines as dictated by the D.C. Department of Aging. Regular reviews of evidence are conducted by the District of Columbia to ensure the guidelines are up-to-date and rely on the most current peer-reviewed evidence and professional standards. The sources of evidence and professional standards used by the LTCMP include, but are not limited to:

- American Diabetes Association.
- American Heart Association.
- American Lung Association.
- Administration on Aging.
- American Society on Aging.
- National Council on Independent Living.
- Centers for Disease Control and Prevention.
- National Institutes of Health.

NCQAHealth's Program and Policy Review Committee evaluates the LTCMPs content and guidelines biannually for the alignment with current evidence and the CMSA Practice Guidelines and other outside evidence and professional standards (See Supplemental Material 1, 2). The Committee consists of long-term services and supports professionals including nurses and social workers and provides suggestions on whether changes, removals or additions to the guidelines should be done. The Committee meets every January and June of each calendar year. In the case that peer-reviewed evidence does not exist for a particular practice or service, professional standards may be used instead. Additionally, designated LTCMP staff can review materials that are submitted for consideration for updates to existing content and materials or the inclusion of new materials (See Supplemental Material 3).

All materials provided to individuals in the LTCMP are consistent with the most current evidence and professional standards and reviewed biannually by the Program and Policy Review Committee. The Committee provides suggestions on updates to the materials provided to individuals based on current evidence and professional standards. These materials include, but are not limited to:

- Educational materials giving tips on managing their conditions (e.g. Tips on Managing Your Risk of Falls).
- Brochures detailing the mission of and services provided by the NCQAHealth LTCMP.

NCQAHealth LTCMP staff are annually trained on the most current techniques and evidence-based practices in long-term care and case management. New case managers are oriented to the program protocols and requirements as part of their 3-month probationary period. This training includes but is not limited to:

- The principles of case management in a community setting.
- Person-centered care planning.
- Evidence-based assessments and services.
- Cultural competency based on the US Health Resources and Services Administration's "Effective Communication Tools for Healthcare Professionals: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency" tool.

LTCMP Staff are also required to complete HIPAA training and subsequent maintenance training every year.

The NCQAHealth LTCMP is committed to being culturally sensitive, meeting the linguistic and cultural needs of its client population. The LTCMP provides all educational materials for program participants in Spanish and English, hires bilingual case managers and gives participants 24/7 access to interpreters to provide the most person-centered care. Biannually, the Program and Policy Review Committee assesses the cultural and linguistic options provided by the LTCMP for their appropriateness in serving the targeted population. If the Committee finds the current materials and options are not in alignment with the demographics of the LTCMPs current clients or service area, they will provide suggestions to update as necessary. Understanding the cultural diversity amongst LTCMP participants is key to providing person-centered, effective care across all segments of the population.

Supplemental Material 1. Program and Policy Review Committee Meeting Minutes from January 3, 2017

Meeting:	**Program and Policy Review Committee Meeting**
Date:	**January 3, 2017**
Attending:	**John Johnson, MHA; Mary Jones, MSN, RN; Jim James, MSW; Jessica Gimenez, PhD; Barry Smith, MBA, MPH**
Minutes Organizer:	**John Smith**

Agenda Item: Educational Materials Review	Discussion	Decision
Current Program Content and Clinical Guidelines	The Committee reviewed the Long-Term Case Management Program (LTCMP) content and clinical guidelines for alignment with the most current evidence available. There was general agreement that the program and guidelines are up-to-date with the exception of those surrounding nutrition, which was suggested for removal. One member disagreed with this, stating the current clinical evidence about the importance of nutrition education in frail elderly points to the maintenance of the guidelines. The member suggested updating the guidelines to better fit the target population's needs.	The Committee agreed to maintain the nutrition guidelines provided updates are made by NCQAHealth.

Meeting:	**Program and Policy Review Committee Meeting**
Date:	**January 3, 2017**
Attending:	**John Johnson, MHA; Mary Jones, MSN, RN; Jim James, MSW; Jessica Gimenez, PhD; Barry Smith, MBA, MPH**
Minutes Organizer:	**John Smith**

Agenda Item: Educational Materials Review	**Discussion**	**Decision**
Materials for Participant Education	The Committee reviewed the educational materials made available to individuals in the LTCMP for their alignment with current evidence and professional standards in condition management and understanding their health risks. The Committee found the materials were within current practice and professional standards. Given this finding, the Committee did not suggest updates to be made.	No updates to be made to educational materials.
Agenda Item: Training Materials Review	**Discussion**	**Decision**
Materials for Staff Training	The Committee reviewed the staff training materials for the LTCMP including relevant assessment forms, training curriculum, service plan templates and other materials necessary to provide evidence-based services to individuals in the program. The Committee found that given the updates suggested to the nutritional guidelines as described earlier in the meeting, staff training curriculum should reflect these changes as well. The Committee also suggested providing additional training materials to staff about the importance of nutrition in frail elderly populations and how it is incorporated into their daily care services.	Update current curriculum to reflect changes made in nutritional guidelines. Add more training materials providing more information on nutrition in frail elderly populations.
Agenda Item: Cultural Appropriateness Review	**Discussion**	**Decision**
Program Cultural Appropriateness	The Committee reviewed the cultural appropriateness of the program content and educational materials for participants. It was determined that there was a lack of non-English information related to advance directives and similar content necessary to person-centered planning goals. One member noted that the program should include more educational materials for Spanish-speaking participants relevant to the Hispanic population (e.g. nutrition information). Another member asked the LTCMP to consider the inclusion of materials in languages other than Spanish and English. Specifically, he suggested the program started to include educational materials in Chinese and French, which is consistent with the demographics of the population the LTCMP is serving.	Seek Spanish-language advanced directive materials.
Agenda Item: Conclusion		

Next Committee Meeting: June 1, 2017

Supplemental Material 2. NCQA Health Program and Policy Review Committee Member Roster

Committee Member	Contact Information
John Johnson, MHA America Community-Based Care 1234 Patriots Way New York City, NY 12345	Phone: (555) 555-5555 E-mail: jjohnson@gmail.com
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Jessica Gimenez, PhD Division of Sociocultural Health, California State Health Authority 1234 Lasso Circle San Franscisco, CA 12345	Phone: (555) 555-5555 E-mail: jgimenez@gmail.com
Barry Smith, MBA, MPH Health Education Institute 1234 University Way Minneapolis, MN 12345	Phone: (555) 555-5555 E-mail: bsmith@gmail.com

Supplemental Material 3. Materials Management Review Tracker

	A	B	C	D	E	F	G	H	I	J
1	Date of Submission	Document (include link if relevant)	Status	Requester	Department	Comments for Reviewer	Reason for Review	Reviewer	Reviewer Comments	Final Decision
2	1/2/2017	Tips for Healthy Eating	COMPLETE	Jane Doe, MPH	Education	Please review content to be included in patient orientation packet.	New educational content	John Smith, MD	Tips sheet is very thorough and will help with our nutritional initiative.	APPROVED
3	1/15/2017	Social Determinants of Health Assessm	PENDING	John Johnson, MHA	Field Management	A new SDH assessment was published. We could maybe use some of the items in our own assessment to better track SDHs?	New assessment tool	John Smith, MD		
4	2/20/2017	Caring for Patients Long-Term	COMPLETE	Mary Jones, MSN, RN	Human Resources	Document provides some helpful information for case managers on managing long-term patients.	New training material	John Smith, MD	Information is relevant, but similar content already exists in the current orientation guide for new	DENIED
5	2/21/2017	Directiva anticipada de atencion de la s	PENDING	Jim James, MSW	Field Management	Review the document's appropriateness for use in Spanish-langauge participants. We are missing supplementary materials on advance directives for non-English speaking participants and this could be a great addition.	New educational content; cultural competency	Juanita Jones, DO		
6										

Appendix B. Assessment Process

SPD HRA Four Quadrant Breakdown

NCQA MLTSS Learning Collaborative

SPD HRA Four Quadrant Breakdown: Select the top 5 questions per quadrant in order of importance.

Social Determinants	Medical Conditions
1. Doesn't understand their medical condition(17) *How hard is it for you to understand information about your condition, medicines, or doctor's instructions?* □ Not hard □ Somewhat hard □ Hard 2. Have problems paying utilities (12) *Do you have problems paying your utilities?* □ Utilities (gas, electric, water) □ Rent/mortgage □ Telephone □ None 3. Place of residence (9) *Where do you live?* □ Home with a family member □ Home without a family member □ Friend or family home □ Assisted living home □ Board and care □ Treatment center □ Skilled nursing facility □ Long term acuity care facility □ Homeless □ About to become homeless □ Other 4. Plans to change where they live or who they live with (11) *Do you plan to change where you live or who you live with in the next 6 months?* □ Yes □ No 5. Need help answering these questions (1) *Do you need someone to help you answer these questions?* □ Caregiver □ Legal Guardian □ Family/friend □ No	1. Ability to get an appointment with their doctor in a timely manner in the past 6 months(14) *In the last 6 months how often did you get an appointment at your doctor's office as soon as you needed it?* □ Always □ Sometimes □ Rarely □ Never 2. Have been seen in ED, hospital, urgent care, BH, LTC in last 3 months (16) *In the last 3 months, have you been a patient in or been seen in one of the of the following?* □ Hospital □ Emergency Room □ Urgent Care □ Rehab □ Nursing Home □ Long term acute care facility □ Behavioral/mental health clinic/hospital □ None 3. Miss taking their meds 2 or more times a week (20) *Do you miss taking your medicines 2 or more times a week?* □ Forget to fill □ Forget to take □ Can't get them □ Side effects □ Hard to take/swallow 4. Take any over the counter meds or prescription meds (19) *Do you take any over the counter or prescription medicines?* □ Yes, 5 or less □ Yes, 6 or more □ No 5. How they rate their health (21) *Select the word that best describes your health?* □ Good □ Fair □ Poor

NCQA MLTSS Learning Collaborative

SPD HRA Four Quadrant Breakdown: Select the top 5 questions per quadrant in order of importance.

Functional Capacity	Behavioral Health
1. Need help with any ADLs (29) *Do you have help with daily activities such as taking a bath/shower, grooming, etc.?* □ I have help □ I don't need help □ I get help and it's not enough □ I need help, I don't have any 2. Lost their balance or fell (23) *Have you lost your balance or fell in the last 12 months?* □ Yes □ No 3. Need help making, eating or getting food (30) *Do you have help making food, eating, or getting food?* □ I have help □ I don't need help □ I get help and it's not enough □ I need help, I don't have any 4. Need help for transportation, paying bills, writing checks, or doing house chores (31) *Do you have help for transportation, paying bills, writing checks, or doing home chores?* □ *I have help* □ *I don't need help* □ *I get help and it's not enough* □ *I need help, I don't have any*□ I have help □ I don't need help □ I get help and it's not enough □ I need help, I don't have any 5. Need changes to their home (10) *Do you need any changes to your home to assist you? Examples may be wheelchair ramp, grab bars in bathroom or other modifications* □ Yes □ No	1. Have physical or emotional problems (22) *Do you have physical or emotional problems that make it hard for you to do your daily routine?* □ Yes, emotional problems □ Yes, physical health problems □ None 2. Have problems their memory (25) *In the past 3 months, did you have any problems with your memory?* □ I can't remember recent events □ Unable to do regular activities □ I fully depend on others for needs □ Can't remember people □ Get lost in familiar places □ Other: ____ □ None 3. Getting therapy for physical or mental needs (28) *Are you getting therapy for physical, mental or speech needs?* □ I have help □ I don't need help □ I get help and it's not enough □ I need help, I don't have any 4. Lost interest or pleasure in things (33) *Over the last 2 weeks have you: Had little interest or pleasure in doing things?* □ Not at all □ More than half of the days □ Several days □ Nearly every day 5. Smoke or use tobacco products (38) *Do you smoke or use tobacco products?* □ Yes □ No

NCQA MLTSS Learning Collaborative

SPD HRA Four Quadrant Breakdown: Select the top 5 questions per quadrant in order of importance.

Preliminary Findings:

- *Living in a Facility* was significantly associated with an unplanned transition. The *"living in a facility"* category includes living in an assisted living home, board and care, long term acute care facility, skilled nursing facility, intermediate care facility, and treatment center. An *unplanned transition* is defined as an emergency room visit that results in a hospitalization.

- Our 2015 CMC and MCLA data has shown that septicemia is the primary diagnosis causing an unplanned transition (ER to hospitalization)

Manchanda, Rishi and Gottlieb, Laura, HealthBegins (2015)— Upstream Risks Screening Tool & Guide

HealthBegins

Upstream Risks Screening Tool & Guide

"Everyone deserves the opportunity to have a safe, healthy place to live, work, eat, sleep, learn and play. Problems or stress in these areas can affect health. We ask our patients about these issues because we may be able to help."

Domain*	Minimum Frequency**	Question	Response	Suggested Scoring	Referral Plan Complete?
Education	First visit	1a. What is the highest level of school you have completed? Check one.	☐ Elementary School ☐ High School ☐ College ☐ Graduate / Professional School	+1 for "Elementary School "	☐
		1b. What is the highest degree you earned? Check one.	☐ High school diploma ☐ GED ☐ Vocational certificate (post high school or GED) ☐ Associate's degree (junior college) ☐ Bachelor's degree ☐ Master's degree ☐ Doctorate	+1 for "High School Diploma, GED, or Vocational Certificate)	☐
Education	First visit & annually	1c. Are you concerned about your child's learning, performance, or behavior in school?	☐ YES ☐ NO ☐ Not applicable	+1 for YES	☐
Employment	First visit & biannually	2. Choose one of the following. Which best describes your current occupation?	☐ Homemaker, not working outside the home ☐ Employed (or self-employed) full time ☐ Employed (or self-employed) part time ☐ Employed, but on leave	+1 for: "Employed, but on leave for health reasons"; "Unemployed"; OR	☐

*Several domains have been adapted from (Institute of Medicine). 2014. Capturing social and behavioral domains and measures in electronic health records: Phase 2. Washington, DC: The National Academies Press
**Suggested minimum frequency of screenings for new and ongoing patients

			for health reasons ☐ Employed but temporarily away from my job (other than health reasons) ☐ Unemployed or laid off 6 months or less ☐ Unemployed or laid off more than 6 months ☐ Unemployed due to a disability ☐ Retired from my usual occupation and not working ☐ Retired from my usual occupation but working for pay ☐ Retired from my usual occupation but volunteering	"Retired...not working" or "…working for pay"	
Social Connection & Isolation	First visit & annually	3. What is your marital status? Check one.	☐ Married ☐ Living with partner ☐ Widowed ☐ Divorced ☐ Separated ☐ Never married	+1 for "Widowed", "Divorced", "Separated", or "Never Married"	☐
		4a. In a typical week, how many times do you talk on the telephone with family, friends, or neighbors?	Number of times per week _____	+1 if total of 4a plus 4b is less than 3 times / week	☐
		4b. How often do you get together with friends or relatives?	Number of times per week _____		
		4c. How often do you attend religious or faith-based services?	Number of times per year _____	+1 if less than 4 times /year	☐

*Several domains have been adapted from (Institute of Medicine). 2014. Capturing social and behavioral domains and measures in electronic health records: Phase 2. Washington, DC: The National Academies Press
**Suggested minimum frequency of screenings for new and ongoing patients

		4d. How often do you attend meetings of the clubs or organizations you belong to?	Number of times per year _____	+1 if less than 2 times/ year.	☐
Physical Activity	First visit & biannually	5a. On average, how many days per week do you engage in moderate to strenuous exercise (like walking fast, running, jogging, dancing, swimming, biking, or other activities that cause a light or heavy sweat)?	Days per week _____	Multiply answers from #5a and #5b to get Total minutes/week	☐
		5b. On average, how many minutes do you engage in exercise at this level? Check one.	Number of minutes ☐ 0 ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 60 ☐ 90 ☐ 120 ☐ 150 or greater	+1 if total is less than 150 minutes/week	
Immigration	First visit	6. Do you have concerns about any immigration matters for you or your family?	☐ YES ☐ NO	+1 for YES	☐
Financial Strain – Overall	First visit & annually	7a. Do you ever have problems making ends meet at the end of the month?	☐ YES ☐ NO	+1 for YES	☐
		7b. How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is..	☐ Very hard ☐ Somewhat hard ☐ Not hard at all	+1 for "Very" or "Somewhat Hard"	☐
Housing Insecurity	First visit & annually	8a. In the last month, have you slept outside, in a shelter, or in a place not meant for sleeping?	☐ YES ☐ NO	+1 for YES	☐
		8b. In the last month, have you had concerns about the condition or quality of your housing?	☐ YES ☐ NO	+1 for YES	☐
		8c. In the last 12 months, how many times have you or your family moved from one home to another?	Number of moves in past 12 months _____	+1 for 2 or more moves in past year	☐
Food Insecurity	First visit & annually	9. Which of the following describes the amount of food your household has to eat: (Check one.)	☐ Enough to eat ☐ Sometimes not enough to eat ☐ Often not enough to eat	+1 for "Often not enough to eat"	☐

*Several domains have been adapted from (Institute of Medicine). 2014. Capturing social and behavioral domains and measures in electronic health records: Phase 2. Washington, DC: The National Academies Press
**Suggested minimum frequency of screenings for new and ongoing patients

Dietary Pattern	First visit & bi-annually	10a. How many pieces of fruit, of any sort, do you eat on a typical day?	Number of pieces/ day _____	+1 if less than 2 a day	☐
		10b. How many portions of vegetables, excluding potatoes, do you eat on a typical day?	Number of portions/ day _____	+1 if less than 4 a day	☐
Transportation	First visit & bi-annually	11. How often is it difficult to get transportation to or from your medical or follow-up appointments?	☐ Does not apply ☐ Never ☐ Sometimes ☐ Often ☐ Always	+1 for "Often" or "Always"	☐
Exposure to Violence	First visit &annually	12. Do you have any concerns about safety in your neighborhood?	☐ YES ☐ NO	+1 for YES	☐
Exposure to Violence	First visit & annually	13a. Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	☐ YES ☐ NO	+1 for YES	☐
		13b. Within the last year, have you been afraid of your partner or ex-partner?	☐ YES ☐ NO	+1 for YES	☐
		13c. Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?	☐ YES ☐ NO	+1 for YES	☐
		13d. Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?	☐ YES ☐ NO	+1 for YES	☐
Stress	First visit & biannually	14. Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his/her mind is troubled all the time. Do you feel this kind of stress these days?	☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much	+1 for "Somewhat", "Quite a bit" or "Very Much"	☐

Appendix C. Person-Centered Care Planning and Monitoring

Institute for Healthcare Communication, Inc. (2011)—Choices & Changes: Communication Tools, Techniques & Strategies: Summary

Institute for Healthcare Communication, Inc.
171 Orange Street, 2R
New Haven, CT 06510-3111
800.800.5907
info@healthcarecomm.org
www.healthcarecomm.org

CHOICES & CHANGES:
Communication Tools, Techniques & Strategies: Summary

1. ASSESS – ASK BEFORE TELL

Open-ended inquiry	▪ Requests a story, not an answer ▪ Search is for meaning, not facts ▪ Simple requests - "Tell me..." ▪ "What" and "How" questions are effective ▪ "Why" questions aren't; they provoke defenses ▪ If a person can answer in one word (yes, no, a number) the question was not open-ended
Ask Screening Questions	▪ **Ask about risk** *"All of us at one time or another do things that aren't good for us. It might be something like not wearing a seat belt or perhaps drinking more than we should. What behaviors have you been doing that might put you at risk?"* ▪ **Ask about therapy or self-management** *"Most of us forget to take our medication or follow through with diet or exercise at some point or another. What difficulties have you had with managing or treating your _____?"* ▪ **Ask about health** *"What are you doing these days that you believe is contributing to y our health*
Assess Agenda/Priorities	▪ *"Which of these areas would you like to address today?"* ▪ *"Here is what I propose we work on today...what are your thoughts?"*
Assess conviction	▪ **Discover and discuss the patient's convictions**: *"How important is this change to you?"* *"How committed are you to making this change?* ▪ Ask the patient to **quantify**: *"On a scale of 0 to 10, how convinced are you that it is important to _____ (make this change)?"*

Assess confidence	▪ **Discover and discuss the patient's confidence**: *"How confident are you that you can make this change?"* *"How likely do you think it is that you will be able to make this change?"* ▪ Ask the patient to **quantify**: *"On a scale of 0 to 10, how confident are you that you can _____ (make this change)?"*
Identify interaction between conviction and confidence	▪ Does the patient lack both conviction (is ambivalent) and confidence (feels helpless) and is therefore **unaware or cynical** about changing? ▪ Is the patient convinced that change is important but lacks confidence and is stuck and **frustrated** regarding change? ▪ Is the patient confident in his/her ability to change but lacks conviction about the need to change and is **skeptical** about changing? ▪ Is the patient both convinced that change is important and confident that she or he can achieve the desired change and therefore is motivated and **moving**?
Assess Stage of Change	▪ **Pre-contemplation** – not thinking about change in the near future ▪ **Contemplation** – thinking about change, but ambivalent and not will to commit to action ▪ **Preparation** – taking steps toward change, but not meeting criteria for action ▪ **Action** – taking action, meeting criteria, but for less than 6 months ▪ **Maintenance** – meeting criteria for action for more than 6 months; still actively monitoring ▪ **Termination/identification** – "permanent" change; part of self-concept **Ask**: 1. "Are you willing to consider changing this behavior now or in the near future?" (If no = precontemplation) If yes, go on to next question 2. Have you taken any steps to change this behavior recently? (if yes and yes to Q1 = preparation; if no and yes to Q2= contemplation). 3. "Are currently meeting the (goal for successful action) (If yes = either action or maintenance - ask question 4) 4. "For how long have you been consistently ……..(meeting the goal)?" (If >6 mo. = maintenance; if <6 mo. = action)
Assess the patient's understanding of the resources s/he needs to change.	▪ What resources does the patient have? ▪ What does the patient believe is needed to make the change? ▪ What access does the patient have to resources? ▪ What barriers might get in the way?
Other potential targets of assessment:	▪ Behavior - what the person is currently doing ▪ Beliefs (including cultural beliefs, values, expectations, pros/cons, perceived vulnerability/threat, perceived benefit, perceptions about treatments and their efficacy) ▪ Feelings, emotions, worries, concerns, distress ▪ Knowledge ▪ Literacy ▪ Skills ▪ Past experience with change ▪ Function/quality of life

Skills Summary / Techniques for Choices & Changes

2. BUILD RAPPORT	
Reflective Listening	**Goal:** Listen, express interest and understand the meaning of what the speaker is saying **Tasks**: ▪ **To be a mirror, reflecting the speaker:** o Repeat the words that you have heard o Short summaries o Reflect meaning ▪ Note patient's response to reflections: every reflection opens a possibility: the speaker may correct, verify, add, refine ▪ **Refine reflection** - As mirrors we all have flaws—we learn about our distortions and misinterpretations as we attempt to accurately reflect
Empathy	**Goals:** ▪ Strive to understand the "other" at a deeper level: emotions, thoughts, values ▪ The person experiences being seen, heard understood **Tasks**: ▪ **Attend to and reflect the other's expressed thoughts, emotions, values** ▪ **Express understanding**: o Normalize, legitimize o Affirm - acknowledge and express respect for coping efforts o Self-disclose, when appropriate
Non-verbal communication to enhance rapport:	▪ attentive eye-contact, open posture, leaning forward ▪ send a signal of understanding through nods, sounds, movement ▪ absence of judgmental body posture, gestures ▪ align self with patient when appropriate (e.g., looking at results, working with a menu of options)
Support autonomy - establish a collaborative clinical relationship to promote change	▪ Acknowledge and support a patient's right to make autonomous choices. ▪ Recognize and respect the patient's competence ▪ Provide a menu of options.
Avoid Arguments	
Roll with Resistance	**OARS** ▪ **Open-ended inquiry** ▪ **Affirmation** ▪ **Reflection** ▪ **Summaries**

Skills Summary / Techniques for Choices & Changes

3. TAILOR THE METHOD TO MATCH THE PATIENT'S CONVICTION AND CONFIDENCE: AGREE ON GOALS AND ASSIST

Enhancing Conviction

- Identify priorities
- Negotiate goals
- Offer menu of options and support choice
- Provide ***new*** information when it is relevant. Ask the patient's permission first
- Explore ambivalence
  - ***"What's the down side of taking action?"***
  - ***"What are the good thinks about staying the same?"***
  - ***"What are the good things about changing?"***
  - ***"What's the down side of staying the same?"***
  - ***"What would you have to give up in order to make this a priority?"***
  - Use decisional balance sheet asking patient to list reasons for change (and for not staying the same) on one side, and reasons for not changing (and for staying the same) on the other.
- Respond to ambivalence
  - Simple reflection and summaries
  - Double-sided reflection ("So, on the one hand….while on the other hand…..")
  - Empathy
  - Acknowledge, appreciate , affirm and express support for change talk and conviction language
    - Change talk
    - Desire
    - Ability
    - Reasons
    - Need
  - Commitment language
    - Vow (strongest commitment)
    - Promise
    - Will
    - Plan to
    - Consider
    - Might
    - Hope to (weakest commitment)
- Use the conviction scaling question and ask the patient:
  - ***" What led you to rate your confidence an X and not zero?"***
  - ***"What would have to happen to move your conviction from an x to (x + 1 or 2)?"***
  - ***"What could I do to help you understand the importance of doing more?"***
- Other strategies enhancing conviction
  - Clarify a values hierarchy
  - Develop and point out the discrepancy between values and current behavior

Skills Summary / Techniques for Choices & Changes

	○ Identify optional reward systems
Enhancing Confidence	▪ Assist the patient to: ○ Recall times in the past when she/he has been successful making changes ○ Define small realistic and achievable steps that are likely to lead to success ○ Identify specific barriers • *"What will (or might) get in the way?"* • *"Anything else?"* (keep asking till list exhausted) ○ Problem-solve around barriers • *"What might help you to overcome that barrier?"* • *"Anything help in the past?"* • *"Any other ideas?"* (brainstorm) • *"Here is what others have done."* • *"Here is what the literature suggests is useful in addressing that barrier."* • Rate ideas *("How effective would x strategy be?)* • *"Ok, now what is your plan."* ○ Provide tools, resources ○ Teach skills (demo, trial, feedback, repeated practice) ○ Attend to progress (monitoring) ○ Anticipate and plan for slips and relapses • Review past lapses, and relapses • Identify perceived triggers • Teach coping skills to address triggers (Avoid, Alter and Substitute) • Anticipate and plan for abstinence violation effect (feelings of guilt/shame in response to lapse leading to demoralization and full relapse) ♦ Normalize ♦ Reframe as an opportunity to learn about triggers and plan more effectively ♦ Teach cognitive skills to combat negative thinking assoc. with lapse ○ Use the conviction scaling question and ask the patient: • *" What led you to rate your confidence an X?"* • *"What would help you (or what would you need) to move your confidence from an x to (x + 1 or 2)?"* • *"What could I do to help you increase your confidence?"*
Tailoring to interaction between Conviction and Confidence	**Low Conviction and Confidence: Decreasing cynicism or increasing awareness** Intervention with a patient who is unaware of the need to change or is cynical reflects both a lack of conviction and confidence. The task is to increase both in the patient. This can be achieved by: ▪ Providing new information (with permission) ▪ Exploring the patient's priorities and respecting their agenda. ▪ Offering options including just thinking about change ▪ Accepting the situation and the patient even though you disagree with the behavior. ▪ Offering your help when the patient is ready to work on increasing knowledge and change. ▪ Expressing empathy; building rapport

Skills Summary / Techniques for Choices & Changes

Tailoring to interaction between Conviction and Confidence *...continued...*	**High Conviction/Low Confidence: Decreasing frustration** Intervention with a patient who is convinced of the need to change but lacks confidence in his/her ability to achieve success requires building, supporting, and increasing the patient's self confidence. This can be achieved by: ▪ Building on the patient's past experience and self assessment of competence. ▪ Identifying small "doable steps". ▪ Identifying barriers and problem-solving ▪ Teaching the patient how to problem-solve ▪ Emphasizing the importance of the patient making choices. ▪ Rewarding achievement with praise. ▪ Expressing empathy; building rapport
	High Confidence/Low Conviction: Decreasing skepticism Intervention with the patient who is self confident and feels powerful in his or her ability to make change, but lacks conviction that anything needs to be done is often very skeptical. The task is to help the patient sort out the ambivalence and decide what is most valuable for him or her. This can be done by: ▪ Explore ambivalence ▪ Elicit and respond to change talk and commitment language ▪ Offer multiple options including thinking about change ▪ Discuss the patient's values hierarchy ▪ Heighten discrepancy between goals and values and actual behavior ▪ Express empathy; Build rapport
	High Conviction/High Confidence – Moving: Maintaining Intervention with the patient who is both convinced of the need to change and in his or her ability to change requires ongoing support and plans for dealing with obstacles. This can be done by: ▪ Planning for relapse ▪ Removing obstacles ▪ Attending to progress ▪ Express empathy; Build rapport

Skills Summary / Techniques for Choices & Changes

Summary of Intervention Techniques		
Assess	▪ Open-Ended Inquiry ▪ Ask Screening Questions ▪ Assess Agenda ▪ Assess Conviction ▪ Assess Confidence	
Build Rapport	▪ Reflective listening ▪ Empathy ▪ Non-verbal skills	
Tailor to Conviction & Confidence: **Agree on Goals and Assist**	**To Enhance Conviction**	**To Enhance Confidence**
	▪ Identify priorities ▪ Negotiate goals ▪ Offer menu of options/Support choice ▪ Provide information/ Advise (with permission) ▪ Explore and respond to ambivalence ▪ Elicit and respond to change talk / commitment language ▪ Conviction scaling and follow-up	▪ Review past experience ▪ Define small achievable steps for success ▪ Identify barriers and problem-solve ▪ Provide tools, resources ▪ Teach skills ▪ Attend to progress ▪ Reframe slips ▪ Confidence scaling and follow-up
Arrange Follow-up	▪ Develop action plan with specific behavioral goals and strategies ▪ Plan for visits, calls ▪ Arrange referrals	

Skills Summary / Techniques for Choices & Changes

BACK HOME APPLICATION

Below, describe two communication techniques (see Techniques section – YELLOW pages) that you want to try out in your clinical work during the next five weeks. Be specific.

Indicate the date when you want to review the impact of adopting these procedures into your practice. Allow yourself at least five weeks before evaluating their utility.

Date to review results: / /

Finally, place this form someplace where you will be sure to see it, as a reminder of the "clinical trial" in communication that you are conducting.

Depending on the mandate of the facilitator, you may receive (at approximately 5 weeks post workshop) a follow-up survey to provide the IHC-C with feedback about your experience in practicing these skills with your patients.

Briefly rewrite these same technique choices on your Participant Information form and return that form, along with the participant evaluation to your facilitator. Thanks!

Procedure One

Anticipated Outcomes

Procedure Two

Anticipated Outcomes

Erie County Department of Senior Services (2016)—Person-Centered Care Plan Policy and Procedure

PHILOSOPHY:

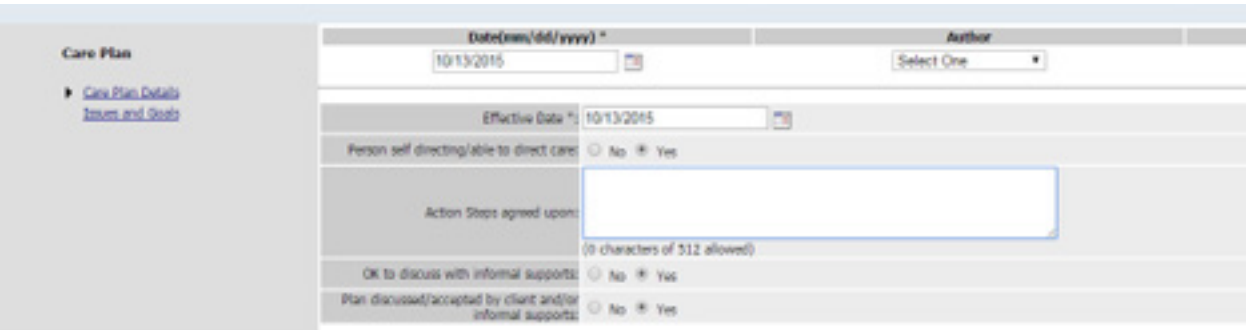
A person-centered care plan must include what is important to the client. A person-centered care plan will include individualized goals that are clearly stated. Each goal will have a clearly defined follow up schedule. The Case Manager documents the person-centered care plan. The Case Manager monitors and documents the goal progress. The person-centered care plan can include "self-management plans." Self-management plans are activities undertaken by the client to help the client manage their condition or attain goals. These activities are designed to shift the focus from the practitioner or care team to the individual. Self-management activities are components of the care plan and do not require a separate care plan. Self-management plans are developed collaboratively with the client and specifically address what action(s) the client will undertake. Those who review the Care Plan and Case Notes will be able to "hear" what is important to the client regardless of the reviewer's level of direct interaction with the client. Case Managers facilitate referrals to resources when necessary. Referrals made by the Case Manager will be clearly documented in the Care Plan, Case Notes and the Community Referrals screen in PeerPlace.

POLICY:

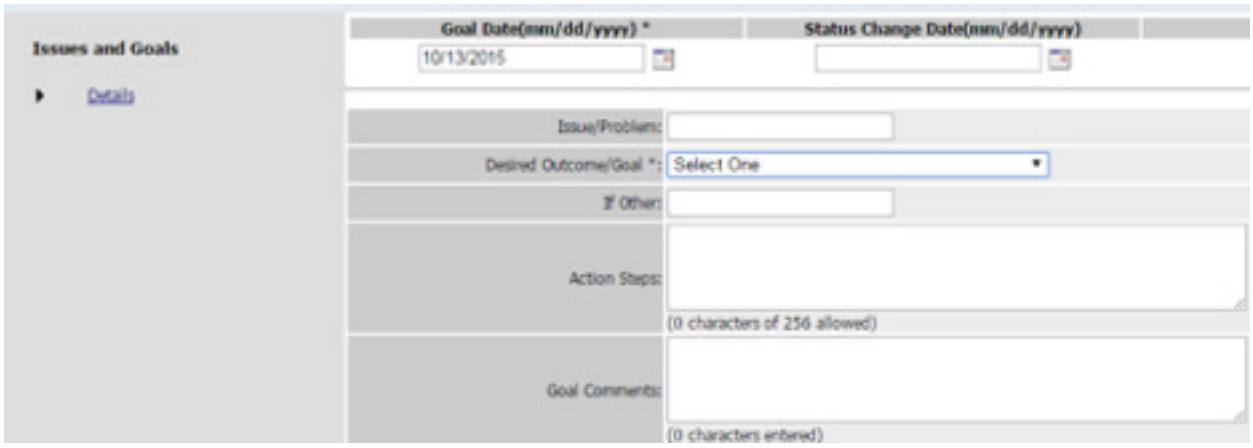
Case managed clients and/or home delivered meal clients must have a personalized care plan with stated goals. Goals in the care plan may address the client's lifestyle, health, physical function(s), social function(s), etc. Goals must be prioritized and clearly documented. Case Managers will assess for barriers to goal completion. Case Managers will document that barriers were assessed for, even if no barriers are identified. Examples of barriers can include: the client's understanding of his/her condition, financial limitations or transportation limitations. Case Managers and their clients will develop a follow up schedule of at least, but not limited to, the service monitoring schedule to track goal progress. For example, Ms. Smith receives EISEP home care and Home Delivered Meals. Ms. Smith would like to learn a new language. The Case Manager would check in with Ms. Smith at least bi-monthly to see how Ms. Smith is progressing on her goal of learning a new language. An example of a self-management plan within this goal can be: Ms. Smith will maintain her prescribed diet and Ms. Smith will log her daily food intake. The Case Manager provides linkage and support, as needed, through the goal process. Referrals made by the Case Manager must be clearly documented in the Care Plan, Case Notes and the Community Referrals screen in PeerPlace.

PROCEDURE:

All case managed clients and/or home delivered meal clients will have a person-centered care plan completed in PeerPlace. The person-centered care plan will be documented in the Care Plan section, Issues and Goals section (if more space is needed), and in the Case Notes.



Case Managers document the person-centered care plan in the Action Steps agreed upon comment box. The Case Manager will state the goal, the action to be taken and the follow up schedule. Due to the limited number of characters allowed, the Case Manager can also use the Goal Comments section in the Issues and Goals tab, see below. There may be/should be multiple goals listed per care plan. The Case Manager documents the care plan and barriers to goal achievement in the Case Notes section. The subject of the case note will be Care Plan so the case note can be easily recognized.



The Care Plan is given to the client immediately upon completed documentation of the Care Plan.

Appendix D. Measurement and Quality Improvement

National Committee for Quality Assurance (n.d.)—Quality Improvement Activity (QIA) Form and Instructions for CM LTSS 5 and HPA LTSS 2 B-E: Quality Measurement

Quality Improvement Activity (QIA) Form and Instructions for CM LTSS 5 and HPA LTSS 2 B-E: *Quality Measurement and Improvement*

When to Use the QIA Form

This document is a guide for completing NCQA's Quality Improvement Activity (QIA) form, which may be used to meet CM LTSS 5 (or LTSS Module 2) Elements B–E. Submit a QIA for each measure you present by attaching it to the applicable element in the Survey Tool using the **Attach Document** feature in the Survey Tool.

Detailed instructions on attaching documents to the Survey Tool are found in the Survey Tool Instructions under **Help** on the Main Menu bar.

The purpose of the QIA form is to *summarize* activities that an organization uses to demonstrate it meets the requirements of Elements B–E. Your organization must designate whether the measure and activity meet Elements B-D (tracking and analyzing three performance measures), or Element E (action and remeasurement).

The QIA Form

The form's five sections

The QIA form is divided into five sections:

- *Section I* Activity Selection and Methodology*
- *Section II* Data/Results Table*
- *Section III* Analysis Cycle*
- *Section IV* Taking Action to Improve/Interventions Table**
- *Section V* Remeasurement **

**For measures submitted for Elements B-D.*
For measures submitted for Element E* ***only.

Submitting the completed form in ISS

Submit the completed form with your ISS Survey Tool, attached to the applicable elements in CM-LTSS 5.

Use the following naming convention:

- Program measure QIA.doc

For example:

- Timeliness of Completion of Initial Assessment QIA.doc
- Experience with Case Management Services QIA.doc
- Readmission Rates QIA.doc

The worksheet helps you make sure you have submitted QIAs for all programs and required elements.

Measure name and activity objective examples

The form first asks for the program and measure name and a rationale for selecting the measure. Because the ultimate goal of measurement is to improve performance, name the improvement goal or activity objective. For example, the measure name may be *Timeliness of Completion of Initial Assessment*. The activity objective must have an action word that accurately states what the activity is designed to do (e.g., "improving," "increasing," "decreasing," "monitoring"):

- Improving Number of Completed Initial Assessments
- Monitoring the Rate of Multiple Contacts to Complete Assessments.

Indicate whether the measure and (if applicable) the activity meet the requirements for Elements B-E.

Section I:
Activity Selection and Methodology

Complete This Section for All Measures (Elements B–D)

This section asks for the rationale for this QIA and measure. Explain why the activity affects individuals.

Indicate whether the activity and measure meet the requirements for Elements B- E.

A. Relevant Measure and Rationale

Rationale

- Why was this measure or activity chosen over others?
- Why is it important to the individuals you serve?
- Why is it worth the resources your organization will expend?

Use objective information. Focus on the activity's importance for your organization.

It is not necessary to provide generic defenses for most LTSS issues. For example, do not include explanatory phrases such as "about 70 percent of people 65 and older will use LTSS at some point in their lives." Nor is it necessary to provide literature sources regarding the importance of an issue unless the topic is unusual.

Importance of activity

Include pertinent organization data or community demographic data that reflect the activity's importance to the eligible population. Use quantifiable terms to describe the magnitude of the issue related to the activity.

Example

Between 2015 and 2016, the number of individuals experiencing an unplanned transition rose by 9 percent. This was the largest increase in care transitions in 3 years. Research has shown that working with individuals on medication adherence can help reduce the risk of them returning to the hospital.

The state requires an initial assessment to be completed within 30 days of enrollment; however, about 10% of the population we serve has no permanent address, and can be very difficult to locate. These individuals are at high risk of ED use unless we can locate them and connect them to housing, nutrition services and very often, counseling.

B. Quantifiable Measure Description

Clear and accurate description

List the quantifiable measure you use in this activity. It should clearly and accurately measure the activity being evaluated. List the baseline benchmark and goal. If you modify it over time, list the updated benchmark or goal in the table in Section II.

Denominator

Describe the event being assessed or the individuals who are eligible for the service or care. Indicate whether all events or eligible individuals are included, or whether the denominator is a sample. For example:

- All individuals eligible for LTSS programs
- All individuals, who were in the program from January 1–December 31 of the measurement year.
- All survey respondents.

Numerator Describe the criteria being assessed for the service or care:

- All complaints from individuals served about understandability of their educational materials
- Enrolled individuals residing in a community setting.

Baseline benchmark Include information about how the benchmark was derived, as well as the benchmark rate. NCQA defines **benchmark** as the industry measure of best performance against which the organization's performance is compared. It should be directly comparable to the QI measure.

Describe the benchmark in numerical terms (e.g., the 90th percentile) or in terms of the comparison group (e.g., the best published rate in our state, 85 percent).

The benchmark may be a best practice in an industry based on published data or the best performance in a corporation with multiple organizations. NCQA requires a benchmark *or* a goal, but does not require both. If you are not using a benchmark, answer "NA" in response to this query.

Benchmarks are not averages; they are the best in class.
The average for a national organization or corporation with multiple organizations is not a benchmark.
The organization's best rate would be considered a benchmark.

Benchmark source If you give a benchmark, list the organization or publication from which it was obtained and the time period to which it pertains.

Baseline goal The **performance goal** is the desired level of achievement for the measure within a reasonable period. It does not have to be based on actual best practices, but it should reflect the level of achievement your organization has targeted.

The goal should be quantitative and stated in numerical terms (e.g., 90 percent, 0.3 appeals per 1,000, three days).

Most organizations do not set performance goals until after they have collected baseline results. If that is the case, enter "NA."

Words such as "improve," "decrease" or "increase" are not acceptable in stating goals unless they are accompanied by a numerical quantifier (e.g., "improve one standard deviation from baseline" or "decrease by 5 percentage points from the last remeasure").

Remember to use the words "percent" and "percentage" precisely.
An increase in satisfaction of individuals served with the education materials from 75 percent to 80 percent is a 5 percentage point increase, not a 5 percent increase.

State the first goal you set (which, generally, is set after baseline results have been analyzed). NCQA expects that as you achieve your goals, you set new ones. Section II has a space to list updated goals. Examples are listed below.

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Goal example

Measure: Percentage of individuals residing in the community with a fall

Numerator: Enrollees residing in a community setting who reported a fall (with or without injury) between January 1 and March 31, 2016.

Denominator: All individuals continuously enrolled in the program from December 1, 2015 through March 31, 2016

Benchmark: <15%

Baseline Goal: <20%

Note: *NCQA does not consider achieving a prespecified goal or benchmark to demonstrate meaningful improvement.*

C. Methodology

This section uses tables, check boxes and narrative to enable you to describe your methodology. The more precisely you describe the data you used and how they were obtained; the sampling procedures, if any, that were applied; and any special factors that could have influenced the results, the more easily NCQA can assess the validity and reliability of the findings.

C.1. Baseline methodology

Briefly describe the baseline methodology.

C.2 Data sources

Check all the data sources used. If you used other sources that are not listed, check "Other" and describe the sources completely. Indicate the number of the measure from Section B next to the data source used.

C.3 Data collection method

This section is divided into three parts:

1. Individual's record
2. Survey
3. Administrative.

Because you may use different data collection methodologies for different measures, check all that apply. Enter the number of the measure from Section B next to the data source used. If you collected survey data using more than one of these techniques, check all that apply. If you used different techniques, or if you used other methods to collect administrative data, mark "Other" and describe your data sources completely. You are not limited to the options provided.

Most of these methods are self-explanatory. Refer to the definitions below.

C.4 Sampling

For each measure that involved sampling, state the sample size, the method used to determine the size and the sampling methodology. If the size is the same for all measures, state "All Measures" and give the information only once. Provide the size of the full population from which the sample was drawn.

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Definitions

Personal interview	A face-to-face interview.
Mail	A survey mailed to a respondent, who returns it—involving no personal contact.
Phone interview	An interview conducted by telephone (without CATI script)
Phone with CATI script	A telephone interview using a computer-assisted script containing prompts beyond the questions that can be used according to a set protocol.
Phone with IVR	A telephone interview involving an interactive voice recognition (IVR) system rather than a live person.
Internet	A survey conducted using the Internet and involving no personal interaction.
Incentive provided	The survey respondent is given an incentive (e.g., gift certificate, cash) to participate. ***Note:*** *Regardless of the survey method, mark this box if the respondent is given an incentive to complete the survey.*
Other	Any other survey methodology different from those listed above.

Remember that the sampling methodology here relates to your baseline measurement only. Any change to this sampling methodology is reported in Section I.D of this form.

Table elements

Measure. You may use the measure number from the measures listed in Section I.B and abbreviate the name.

Sample size. State the number of the full sample selected, including over-sampling. The denominator listed in Section II provides the number included in the measure.

Determining the sample size. Explain the parameters used to determine the sample size, which typically include:

- The assumptions or requirements of the statistical test to be used to verify the significance of observed differences
- The desired degree of confidence in the statistical test (alpha level)
- Statistical power (the sensitivity of the statistical test to detect differences; bigger samples yield greater power)
- The margin of error to be allowed when assessing the hypothesis
- The oversample rate.

The **oversample** is the extra cases included in the sample to replace cases rejected because of contraindications, ineligibility and so on. In survey measurement, the oversample should be large enough to replace expected nonresponses. Examples of oversampling are shown below.

Oversampling example To improve the impact of education materials, you conduct telephone surveys of different groups of individuals served at two points in time, asking them if the information they received changed their self-management practices. You have these expectations:

- The distribution of responses about "how much did the information you received affect your behavior" is normally distributed for both the presurvey and postsurvey groups
- The t-test is used to test the significance of the presurvey and postsurvey differences at alpha = 0.05 and 80 percent power
- A pilot survey showed that the standard deviation of "number of days to referral" responses is 5.25
- The program reduces the average number of days from 8.5 days to 7 days
- The response rate is 85 percent.

Sample size calculations based on the above parameters indicate that you require a sample of 193 completed surveys. You expect that 15 percent of the sampled individuals will not respond, so you sample 227 individuals served to account for the nonresponse (X *0.85 = 193; X = 193/85; X = 227). This calculation includes 193 individuals in the original sample plus an oversample of 34 individuals to replace those who do not respond.

Sampling method State the sampling method (e.g., simple random sample, stratified random sample, convenience sample). State the reasons for exclusions, if there were any (e.g., "Simple random sampling was used. During the claims pull, three claims were excluded because they were miscoded.").

If your sampling method involves a survey, it is not necessary to complete this table because you have included the Survey Tool and the survey protocol (requested in Section I.C.2).

C.5 Data collection and analysis cycles Check the box that applies or describe the frequency of data collection and analysis. Enter the number of the measure from Section B next to the data source used. For many service activities, the data collection cycle is more frequent than the analysis cycle. For example, hospitalization data may be collected weekly but analyzed monthly or quarterly. Survey data may be collected quarterly and analyzed at six-month intervals.

C.6 Other pertinent methodology features Describe other methodological decisions or issues that could affect the analysis of the data or influence the results, such as:

- Coding definitions.
- Data collection specifications unique to your organization.
- Data collection delays.
- Unique survey response if your QIA does not include sufficient data, as specified by NCQA policy, or if you do not believe the results are biased by seasonal issues because of the definition of the measure. Provide the rationale for this for MQ 1.

Mark this section "NA" if there are no other methodological features to be brought to NCQA's attention. You are not required to complete the section past this point.

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D. Changes at Annual Remeasurement

If you are using this form to present two annual measurements, describe methodology changes made after the baseline measurement was taken. To compare results accurately, it is best to use the same method over time, although you may need to change methodology in order to strengthen the validity and reliability of the outcome, correct inadequacies in the initial process or accommodate for a lack of resources. Specifying changes is important because they can influence analysis of the results.

For each affected measure, describe:

- The dates during which the changed method was used
- How the method was changed
- The rationale for the change
- The change's anticipated impact on the analysis.

If you changed the sampling method in the same way for several measures, provide the information only once.

If the sampling method is the same but the sample size has changed, show only that change.

Section II:
Data/Results Table

Complete This Section for All Measures (Elements B–D)

This section contains a table of the baseline measurement results of and all remeasurements that you are presenting for consideration. You may substitute a table of your choice as long as it includes all of the required elements. If there are more than five remeasurement periods, add a row for each additional measure. If you measured a service issue more frequently than quarterly, combine the data by recalculating the numerator and denominator and enter the quarterly result in the table.

Quantitative Result

Enter the date and actual quantitative results for each measurement.

Notes

- *Elements B-D require annual measurement, but the organization is not required to submit the* ***same*** *measure for the second annual measurement for either element.*
- *If the organization is submitting the same measure with two annual results for an element, it may do so in one form and enter the second measurement results and any changes to methodology year to year in Section I.*
- *If the organization is submitting a different measure for the second year annual measure for Elements B-D, it must complete a separate form for that measure.*

Table Description

Date of last measurement	The date on which the measurement was conducted (different from the period covered below). This information is used to help understand the timing of measurement as it relates to prior and subsequent interventions.
Time period measurement covers	State the period covered by the measurement: quarterly (e.g., 1Q 2013), twice a year (e.g., January–June and July–December 2013), yearly (e.g., 2013), or every other year (e.g., January–December 2013 and January–December 2014).
Numerator/ denominator	List the numerator and denominator for each remeasurement period. If the measure uses survey methodology, state the number of people who met the numerator criteria (numerator) and the number of people who responded to the question (denominator).
Rate or results	Convert the fraction (numerator/denominator) to a percentage.
Comparison benchmark/ comparison goal	List the goal or benchmark period in effect during the remeasurement cycle. The comparison goal is blank for the baseline measurement unless there is an established goal before pulling the baseline data. A goal based on baseline data in effect for the first remeasurement cycle should appear in the comparison box on remeasurement line 1. If you met your goal but there is opportunity for improvement, NCQA suggests you increase your goal. If you changed your goal for another reason, explain why in *Section III: Analysis Cycle*. Add benchmarks that you did not have at the baseline period.

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Section III:
Analysis Cycle

Complete this section for All Measures (Elements A- E)

In this section, present the results of the quantitative and qualitative analyses used to interpret the results and identify the opportunities for improvement that you want to pursue. Analyses may include collecting additional data; identifying barriers or causes for less-than-desired performance; and designing strategies to overcome the barriers. Implementation of interventions is covered in Section IV.

A. Time Period and Measures Covered by Analysis

Focus of analysis

Analysis may occur after every remeasurement or after grouping several remeasurement periods. It may focus on one measure, on all measures or on a combination of measures.

You may collect these data quarterly but analyze the data only twice a year. The first analysis period might include only the first and second measure and the second might include all three measures.

An example for improving asthma management could include:

- Measures of ER visits
- Inpatient admissions per 1,000
- Quality-of-life measures from a survey.

For example, if you measured ER visits and inpatient admissions monthly and conducted the quality-of-life survey annually, you could analyze the first two measures quarterly and the quality-of-life measure annually.

If you have multiple analysis periods, it is helpful to label them clearly. For example:

- *Analysis 1:* Calendar year
- *Analysis 2:* Calendar year
- *Analysis 3:* January–December 2012.

B. Identifying and Analyzing Opportunities for Improvement

In this section, address the points specified, as appropriate, for the activity *for each analysis cycle.*

B1. Quantitative analysis

Compare to the goal/benchmark. Did you meet your goals or achieve the benchmark?

Why did the goals change? If you changed the goal, explain why. If you met the goal but there is opportunity for improvement, NCQA expects you to increase the goal. Avoid adjusting goals without having a sound rationale for doing so.

Has the benchmark changed? If you changed the benchmark, indicate the source of the new benchmark and the date it was adopted.

Compare to previous measurements. Have the results increased or decreased since the previous remeasurement? If so, does the change represent an improvement, or deterioration?

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Trends and statistical significance. Describe trends you identified and their significance. What weight do you place on the presence or absence of statistical significance?

Impact of changes in method. Discuss the impact of the changes on actual results. Could the results be biased, positively or negatively, by the changes? Explain.

Overall survey response rate and implications. If any measures in the analysis are based on survey data, give the survey response rate for the entire survey. Describe the impact this response rate could have on the reliability of the findings. Variability in response rates in remeasurement periods should also be addressed (e.g., a ≤20 percent response rate is generally considered too low to draw reliable population-based conclusions).

B.2 Qualitative analysis

Techniques and data used. Many techniques exist for determining barriers or root causes for results. You may need to collect additional data, stratify data or analyze subgroup data in order to understand reasons for the results. Include how you performed the barrier analysis and any additional data collected for barrier analysis. Brainstorming, multivoting, pareto analysis and fishbone diagramming are common continuous quality improvement techniques used to identify barriers to improvement. In addition to stratifying the data you collected to calculate the measure, you may need to analyze the results of other data, such as targeted survey results, complementary data (e.g., complaints in relation to satisfaction survey rates) and results of focus groups.

Expertise of group performing analysis. List the group or committee involved in the analysis; describe the composition of the group and its expertise in evaluating this activity. If statistical or survey research analysis is required, describe the qualifications of those involved. Issues may require expertise in the clinical subject matter as well as an understanding of the delivery system, benefit structure and other distinctive aspects of the organization.

Citations from literature. For many improvement activities, there are identified and accepted sources that contain information about barriers to performance. You may use these sources to supplement, or substitute for, your own barrier analysis. Give the complete citation (i.e., name of article and journal and date of publication) for each source you use.

Barriers/opportunities identified. List the barriers to or causes for the unacceptable performance you identified, if any. Although NCQA recognizes that inadequate data collection may contribute to low performance, it does not accept improvement in data collection alone as an opportunity to improve. Barriers and opportunities for improvement must focus on variables (e.g., improving processes, changing benefits, educating patients and practitioners) that can result in improved performance. Categories that may create barriers:

- Individual's knowledge
- Practitioner knowledge
- Organization staffing
- Communication challenges between LTSS providers and medical providers.

List opportunities for improvement that you identified from the barriers. For example, identify the lack of family involvement in therapy as a barrier to improving depression management for elderly clients. Next, identify as opportunities for improvement the practitioner's lack of knowledge of the importance of family involvement, the family's distance or unwillingness to participate in therapy and the individual's resistance to family involvement. Choose which of these opportunities to focus on and develop one or more interventions.

Although you list interventions in relation to barriers identified in Section IV, you should justify here the causal link between interventions and results you observed. Explain how interventions influenced the outcome; identify interventions that were most influential and explain why; and describe intervening or confounding factors that may have contributed to the changes.

Some barriers do not lead to opportunities because of benefit restrictions, state law or other problems outside the organization's control.

Remember that opportunities are not the same as barriers or interventions.

Barrier example 1	**Barrier:**	Inadequate coverage of phones during lunch and breaks
	Opportunity:	Improve lunchtime and break coverage
	Intervention:	Revised staff scheduling to provide better coverage using existing staff
Barrier example 2	**Barrier:**	Insufficient staff availability
	Opportunity:	Increase staffing
	Intervention:	Recruited three new nurses to meet availability needs

Section IV:
Taking Action to Improve/Interventions Table

Complete This Section *Only for Measures Submitted for Element E*

In this section, list the interventions taken to overcome barriers identified in the previous section.

Note: *You are not required to pursue interventions for all identified barriers.*

Table Description

Date implemented	List the month and year during which the intervention was implemented.
Check if ongoing	Some interventions occur on a regular, ongoing basis. Often, the effectiveness of the intervention rests on its repetitive nature. Check the column stating that the intervention occurs at periodic intervals, then the interval frequency (e.g., monthly, quarterly, annually). For example: • Quarterly newsletters for staff • Annual training and role-play exercises on person-centered care planning.
Intervention	List the interventions chronologically. Generally, interventions are implemented after the data are analyzed. If you began interventions prior to analyzing the baseline measure or prior to this survey period and you believe they have an impact on the performance measures during this survey period, list them first. Interventions may be listed under categories such as Individuals Served, Case managers, LTSS Providers, Collaborative and Systems. Provide a detailed, quantitative definition of the intervention when possible. For example, "hired two social workers" is more specific than "increased staffing." "Mailed lists of 455 noncompliant individuals to 54 case managers" better describes the magnitude of the intervention than "mailed lists of noncompliant individuals to case managers." You may abbreviate the full name of the intervention after using it for the first time. Do not include activities that are planned but have not been implemented (e.g., developing policies, conducting committee meetings or organizing activities).

Remember that you may include interventions taken after the last remeasurement period shown on this form, but they* are not *used by NCQA to determine meaningful improvement.

This list also summarizes your interventions. NCQA surveyors review additional back-up material to document the extent of the intervention and its implementation.

Barriers that interventions address

List all barriers that each intervention is designed to address, which you should have previously described in Section III. You may abbreviate the name of the barrier. It may be helpful to number the barriers and use the numbers in subsequent references.

Do not include barriers related to data collection. An example of a completed Section IV interventions table appears below:

Activity Name: Decreasing falls risk

Section IV: Interventions Table

Interventions Taken for Improvement as a Result of Analysis. List interventions chronologically that had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "hired 4 customer service reps" as opposed to "hired customer service reps"). Do not include the intervention planning activities.

Date Implemented (MM/YY)	Check if Ongoing	Interventions	Barriers That Interventions Address
02/13		Developed training materials on behavioral counseling techniques including identification of issues and appropriate interventions.	Most reasons for individuals' falls are behavioral (e.g., not using a walker. Case managers are uncertain about how to intervene with behavioral issues.
03/13		Train personal care attendants and others who provide services in the home on identification of both physical risks and behavioral reasons for falls and prompt communication of risks to case managers.	Many LTSS providers are unaware of their role as an "early warning system" for falls risks.
03/13		Identified and reviewed the individuals with falls reported in the prior quarter	Inadequate identification and targeting of individuals at risk
5/13		Scheduled individual visits to identify issues and reasons for falls.	Inadequate understanding of risks which may predict falls.
6/13	X	Meet with individuals and devise environmental and behavioral intervention plans. Schedule and make follow-up visits to identify progress.	Inadequate identification, planning and support of behaviors which can reduce falls risks.

Back-Up Information

NCQA wants to review documentation that supports the information you have summarized on your QIA. In addition to the completed QIA form, NCQA may need additional documentation. Your designated ASC will let you know if this applies.

Such information often encompasses:

- All material related to methodology, including data collection tools (e.g., medical record abstraction sheets, codes for administrative data, inter-rater reliability testing, computer algorithms)
- Copies of literature cited, as appropriate
- Excerpts of minutes or other documentation that show how and when analysis was performed
- Tools and supplemental data used in barrier analysis
- Evidence and dates of actions taken:
  - Copies of mailings
  - Newsletters
  - Responses from staff or individuals
  - Revised policies and procedures
  - Excerpts from updated client or practitioner handbooks
  - Revised contracts

Section V:
Remeasurement

Complete This Section *Only for Measures Submitted for Element E*

In this section, list *all* quantifiable measures you use in this activity, including those added over time. The quantifiable measure should measure the activity being evaluated clearly and accurately. List your baseline benchmark and goal; if you modify it over time, list the updated benchmark or goal in the table.

Table Description

Time period measurement covers	The date on which the measurement was conducted (different from the period covered below). This information is used to help understand the timing of measurement as it relates to prior and subsequent interventions.
Numerator/ denominator	State the period covered by the measurement: quarterly (e.g., 1Q 2013), twice a year (e.g., January–June and July–December 2013), yearly (e.g., 2013), or every other year (e.g., January–December 2013 and January–December 2014).
Rate or results	List the numerator and denominator for each remeasurement period. If the measure uses survey methodology, state the number of people who met the numerator criteria (numerator) and the number of people who responded to the question (denominator).
Comparison benchmark/goal	List the goal or benchmark period in effect during the remeasurement cycle. The comparison goal is blank for the baseline measurement unless there is an established goal before pulling the baseline data. A goal based on baseline data in effect for the first remeasurement cycle should appear in the comparison box on remeasurement line 1. If you met your goal but there is opportunity for improvement, NCQA suggests you increase your goal. If you changed your goal for another reason, explain why in *Section III: Analysis Cycle*. Add benchmarks that you did not have at the baseline period.

QUALITY IMPROVEMENT FORM

NCQA Quality Improvement Activity Form

Organization, Program and Measure Information	
Organization:	
Program/Condition:	
Name of Measure:	_____ ☐ Measure 1 (Element B) or ☐ Measure 2 (Element C) or ☐ Measure 3 (Element D)
Activity Objective:	
Measurement Period Date:	*State the period covered by the initial assessment. This is typically an entire calendar year (e.g., January 1, 2013–December 31, 2013).*
Indicate the elements to which this measure applies. Check all that apply.	☐ ***Track and Analyze a Measure of Effectiveness*** **(CM-LTSS 5, HPA LTSS 2, Elements B–D)** *(Required for all programs/conditions.)* ☐ ☐ ***Action and Remeasurement*** **(CM-LTSS 5, HPA LTSS 2, Element E)**

Section I: Activity Selection and Methodology	
Complete for Measure Submitted for:	• **CM-LTSS 5: Elements B-D**
Used to Score:	• **CM-LTSS 5: Elements B-D**
A. Relevant Measure and Rationale. Use objective information (data) to explain your rationale for why this measure is important to individuals *and* why there is an opportunity for improvement. *(CM-LTSS 5, Elements B-D, factor 1.)*	
B. Quantifiable Measure Description. List and define *the* quantifiable measure. Include a goal or benchmark. If a goal was established, list it. If you list a benchmark, state the source. *(CM-LTSS 5, Elements B-D, factors 2-4.)*	
Quantifiable Measure:	
Numerator:	
Denominator:	
Baseline Benchmark:	
Source of Benchmark:	
Baseline Goal:	

C. Methodology *(CM-LTSS 5, Elements B-D, factor 2.)*

C.1. Baseline Methodology.

C.2 Data Sources. Check all that apply.

- ☐ Individual records
- ☐ Administrative data:
  - ☐ Claims/encounter data ☐ Complaints ☐ Appeals ☐ Telephone service data ☐ Appointment/access data
- ☐ Hybrid (medical/treatment records and administrative)
- ☐ Pharmacy data
- ☐ Survey data (attach the Survey Tool and the complete survey protocol)
- ☐ Other (list and describe):

_____

_____

C.3 Data Collection Methodology. Check all that apply.

If individual records, check below:
- ☐ Record abstraction

If survey, check all that apply:
- ☐ Personal interview
- ☐ Mail
- ☐ Phone with CATI script
- ☐ Phone with IVR
- ☐ Internet
- ☐ Incentive provided
- ☐ Other (list and describe):

_____

_____

If administrative, check all that apply:
- ☐ Programmed pull from claims/encounter files of all eligible individuals
- ☐ Programmed pull from claims/encounter files of a sample of individuals
- ☐ Complaint/appeal data by reason codes
- ☐ Pharmacy data
- ☐ Delegated entity data
- ☐ Vendor file
- ☐ Automated response time file from call center
- ☐ Appointment/access data
- ☐ Other (list and describe):

_____

_____

Sample

C.4 Sampling. If sampling was used, provide the following information.

Measure	Sample Size	Population	Method for Determining Size *(describe)*	Sampling Method *(describe)*

C.5 Data Collection Cycle. *(CM-LTSS 5, HPA LTSS 2, Elements B-D, factor 5.)*

- ☐ Once a year
- ☐ Twice a year
- ☐ Once a season
- ☐ Once a quarter
- ☐ Once a month
- ☐ Once a week
- ☐ Once a day
- ☐ Continuous
- ☐ Other (list and describe):

_____

_____

Data Analysis Cycle. *(CM-LTSS 5, Elements B-D, HPA LTSS 2, factor 5.)*

- ☐ Once a year
- ☐ Once a season
- ☐ Once a quarter
- ☐ Once a month
- ☐ Continuous
- ☐ Other (list and describe):

_____

_____

C.6 Other Pertinent Methodological Features.

D. Changes to Methodology at Annual Remeasurement (if applicable).

Section II: Data/Results Table						
Complete for Measure Submitted for:	• **CM-LTSS 5, HPA LTSS 2: Elements B-D**					
Used to Score:	• **CM-LTSS 5, HPA LTSS 2: Elements B-D, factors 2 and 3.**					
Quantitative Result: List the results. *(CM-LTSS 5, Elements B-D, factors 2 and 3.)*						
Date of Last Measurement	**Time Period Measurement Covers**	**Numerator**	**Denominator**	**Rate or Results**	**Comparison Benchmark**	**Comparison Goal**
Elements A and B require annual measurement.						

Section III: Analysis Cycle	
Complete for Measure Submitted for:	• **CM-LTSS 5, HPA LTSS 2, Elements B-D**
Used to Score:	• **CM-LTSS 5, HPA LTSS 2, Elements B-D, factor 5.**
A. Time Period and Measure Covered by the Analysis	
B. Analysis and Identification of Opportunities for Improvement. Describe the analysis and include the points listed below.	
B.1 Quantitative Analysis *(CM-LTSS 5, Elements B-D, factor 5.)*	
For the quantitative analysis, include analysis of the following: Comparison with the goal/benchmark Reasons for changes to goals (if any) If benchmarks changed since baseline, list source and date of changes Comparison with previous measurements (if any) Trends, increases or decreases in performance or changes in statistical significance (if used) Impact of any methodological changes that could impact the results For a survey, include the overall response rate and the implications of the survey response rate	
B.2 Qualitative Analysis *(CM-LTSS 5, Elements B-D, factor 5.)*	
For the qualitative analysis, describe analysis that identifies causes for less than desired performance (barrier/causal analysis) and include the following: Techniques and data (if used) in the analysis Expertise (e.g., titles; knowledge of subject matter) of the work group or committees conducting the analysis Citations from literature identifying barriers (if any) Barriers/opportunities identified through the analysis	

Stop here if measure WAS NOT selected for interventions to improve (CM-LTSS 5, HPA LTSS 2, Element E)

If measure was selected, complete Section IV: Taking Action to Improve	
Complete for Measure Submitted for:	• **CM-LTSS 5, HPA LTSS 2: Element E**
Used to Score:	• **CM-LTSS 5, HPA LTSS 2: Element E (if measure is submitted for Element E)**

Interventions Taken for Improvement Resulting From Analysis. List interventions chronologically that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "hired 4 DM nurses" as opposed to "hired nurses"). Do not include intervention planning activities.

Interventions

Date Implemented (MM / YY)	Check if Ongoing	Interventions	Barriers That Interventions Address

Sample

Section V: Remeasurement *(CM-LTSS 5, HPA LTSS 2: Element E, factors 3 and 4.)*

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal
	Baseline:					
	Remeasurement 1:					
	Remeasurement 2:					
	Remeasurement 3:					
	Remeasurement 4:					
	Remeasurement 5:					

Quality Measures Workbook

Quality Measures Workbook

Measurement Instructions

Follow these instructions for completing the measurement worksheet in this workbook. Use this workbook to address CM-LTSS 5 Elements B-D (LTSS 2, Elements B-D in HPA).

1. Element B: Track and Analyze a Measure of Effectiveness
2. Element C: Track and Analyze a Second Measure of Effectiveness
3. Element D: Track and Analyze a Third Measure of Effectiveness

The measures worksheet lets NCQA surveyors collect summarized information on the measures that the organization used to evaluate each case
You may expand the size of the cells in the worksheet to convey summarized information; details should be included in the reports that surveyors

Measurement of Effectiveness for Standard CM-LTSS 5 B-D (LTSS 2, Elements B-D in HPA)		
COLUMN	**HEADING**	**INSTRUCTIONS**
A	Program	Populate the name of the program.
B	Name of measure	For each measure presented for CM-LTSS 5, Element B, C and D (LTSS 2, Elements B-D in HPA), enter the name (e.g., Timeliness of Care Plan; Completion of Goal Prioritization).
C	Measure specifications	Use one of the following descriptions, or write a brief description: Process; Outcome; Service utilization. Provide as much detail as possible.
D	Measurement period	Enter the month and year that each measure covers.
E	Data source	List all the sources of data used for the numerator: client- reported, case file, encounter.
F	Denominator	Enter the number of eligible individuals.
G	Sample size (if sample is used)	Enter the size of the sample, if a sample was used. If a sample was used, the sample becomes the denominator.
H	Numerator	Enter the numerator resulting from collecting the data.
I	Result	Column H divided by column F if the whole population was in the measure; column G divided by column F if a sample was used.

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Measures Worksheet

Program	*Name of Measure*	*Measure Specifications/Description*	*Measurement Period*	*Data Source*	*Eligible Population*	*Denominator (=Elig Pop or Sample Size if Applicable)*	*Numerator*	*Result*
Example: Elderly Waiver	Timeliness of Care Plan	Identify clients enrolled in Calendar 2016 whose care plan was finalized and signed off within 30 days of enrolling in the waiver program.	1/1/16 - 12/31/16	Case management file	1,000	1,000	850	0.85
Measure 1:								
Measure 2:								
Measure 3:								

Action & Remeasurement Worksheet

Follow these instructions for completing the Action & Remeasurement Worksheet: The information in this worksheet applies to CM-LTSS 5, Element E: Action and Remeasurement. This worksheet lets NCQA surveyors collect summarized information on the opportunities identified and the actions taken for quality improvement that your organization has identified. Surveyors review organization reports to verify the analysis.

You may expand the size of the cells in the worksheet, as needed, to convey summarized information; details should be included in the reports that surveyors review.

Column	Heading	Instructions
A	Program Related Process or Outcome (CM LTSS 5B-D.1) (HPA LTSS 2B-D.1)	Select three measures or processes that have significant and demonstrable bearing on a defined portion (including all or subset) of the case management population or process so that appropriate interventions would result in significant improvement for the population. Measure details must be included on the Measure Worksheet (Tab 2).
B	Methodology (CM LTSS 5B-D.2) (HPA LTSS 2B-D.2)	Identify the methodology used to produce each measure. Measurement of case management effectiveness includes the use of quantitative information derived from valid measurement methods. NCQA considers the following to evaluate a measure's validity: numerator and denominator, sampling methodology, sample size calculation, measurement periods and seasonality effects.
C	Performance Goal (CM LTSS 5B-D.3) (HPA LTSS 2B-D.3)	Establish an explicit, quantifiable performance goal for each measure. A performance goal is the desired level of achievement that you set for yourself. You may base the goal on external benchmarks, which are known levels of best performance.
D	Measure Specifications (CM LTSS 5B-D.4) (HPA LTSS 2B-D.4)	Use one of the following descriptions, or write a brief description: Process; Outcome; Service Utilization. Specification details must be provided on the Measure Worksheet (Tab 2).
E	Analysis of Results (CM LTSS 5B-D.5) (HPA LTSS 2B-D.5)	Collection of data and analysis of findings includes a comparison of results against goals and an analysis of the causes of any deficiencies (if appropriate). The analysis must go beyond data display or simple reporting of results.
F	Opportunities (CM LTSS 5B-D.6) (HPA LTSS 2B-D.6)	Use qualitative and quantitative analysis to prioritize opportunities to improve. The opportunities may be different each time the organization measures and analyzes the data.
G	Action Taken (CM LTSS 5E.1) (HPA LTSS 2E.1)	Identify one implementation that addresses one or more opportunities identified in CM-LTSS 5B-D. Describe remeasurement using methods consistent with initial measurements. Evaluation of effectiveness may measure either intermediate or ultimate outcomes. In some cases, intermediate measures may give you important information about the intervention.

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Action and Re-measurement Worksheet

Program Related Process or Outcome (CM LTSS 5B-D.1) (HPA LTSS 2B-D.1)	Methodology (CM LTSS 5B-D.2) (HPA LTSS 2B-D.2)	Performance Goal (CM LTSS 5B-D.3) (HPA LTSS 2B-D.3)	Measure Specifications (CM LTSS 5B-D.4) (HPA LTSS 2B-D.4)	Collection/Analysis of Results (CM LTSS 5B-D.5) (HPA LTSS 2B-D.5)	Opportunities (CM LTSS 5B-D.6) (HPA LTSS 2B-D.6)	Action Taken (CM LTSS 5E.1) (HPA LTSS 2E.1)
Measure 1:						
Measure 2:						
Measure 3:						

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Partners in Care Foundation (2016)— MSSP Performance Improvement Projects

Partners in Care Foundation (2016)—MSSP Performance Improvement Projects

NCQA CM 4 and CM 6
MSSP PERFORMANCE IMPROVEMENT PROJECTS
2015 through 2017

Post NCQA accreditation in 2015, Partners initiated an organization-wide Quality Assurance and Performance Improvement (QAPI) Committee using most of the tools and methods of the Centers for Medicare and Medicaid Services (CMS) models. Over the past year and a half, the QAPI Committee has chartered 5 Quality Improvement (QI) initiatives resulting from identified trends and/or the recommendations made by NCQA in its initial survey findings. The implementation of these projects included the use of statistical charting software (i.e., QI Macros). Of the 5 projects, one was implemented organization-wide to address protected health information, and 4 focused directly on the MSSP patient well-being, patient satisfaction, the provisioning of durable medical equipment based on need, and the reporting, tracking, and resolution of MSSP incident reports.

QUALITY IMPROVENMENT PROJECT #1: Initiated December 2015, completed March 2016; on-going monitoring

Project Name: Agency Wide Use and Maintenance of Protected Health Information (PHI)

Background:
Baseline metrics gathered between 7/1/2015 and 10/31/3015 indicated a pattern of incidents out of compliance with Partners policies and procedures and NCQA Standards related to PHI. These patterns are quantifiable: unacceptable numbers of unsecure email messages containing PHI have been received from agencies outside of Partners facilities; and qualitative: staff describe inconsistent use of secure-print capability within Partners and inconsistent compliance of secure-print usage, as well as documents left unsecure on staff desks after hours. A Performance Improvement Project (PIP) team formed to conduct a three-month assessment that would inform the development of recommendations and strategies to address the root cause of these issues.

Goals:
Achieve organization-wide PHI/HIPAA Compliance by improving standard policies and procedures for both internal and external transfer of PHI. Ensure staff has proper training on policies and procedures. Provide opportunities for group training to encourage joint learning and problem solving.

- Develop a clear statement of content considered to be PHI;
- Conduct an inventory of guideline documents, standards, and contracts that reference PHI;
- Conduct an Agency-wide inventory of staff in need of secure-print functionality on E-device(s) and training on Agency policies and procedures;
- Refine and Enforce training requirements on PHI, including who should complete training, how often training is needed, which modules should be completed, what content is included, and determining the approved delivery methods and tools for training.

PIP Summary:
This summary report represents outcomes from an agency-wide inventory informing performance improvement strategies. This is the agency's first sponsored performance improvement project (PIP) and the first use of the quality assurance/performance improvement (QAPI) methodology. The results reflect the comprehensive significance of the security of PHI and other sensitive documentation of information across the agency.

- The PIP Team analyzed survey responses from 108 staff members and conducted an inventory of Partners' standard contract language (business associate agreements) and existing policies and procedures. Survey

1
QAPI: 12/14/2016

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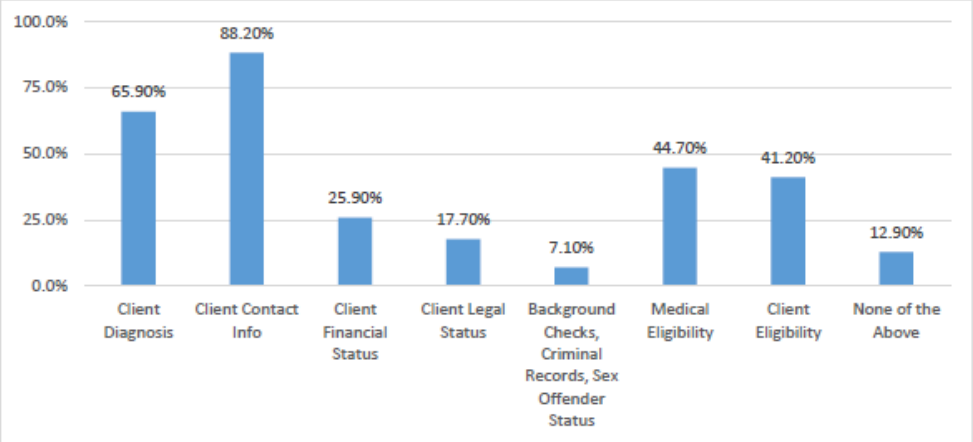
responses primarily informed how staff currently handles PHI and the PIP Team identified gaps between what staff reported and what Partners policies and procedures require. Approximately 70% of survey respondents indicated that they handle PHI and/or other sensitive client information in their work. Following analyses, the PIP Team determined that there is an opportunity to strengthen Partners policies and procedures as well as implement additional IT/security training for all staff to reiterate the definitions of PHI and sensitive information, ensure all staff are aware of the policies required for handling such information, and provide infrastructure (electronic and physical) that enable staff to adhere to all policies.

Summary of Survey Respondents

- **108 Total Participants (82% of 132 Total Staff Members)**

Partners Office	Total*	Percent of Respondents	Percent of Staff in Office	Percent of Total Staff
Kern	19	17.6%	100%	14%
San Fernando	50	46.3%	88%	38%
Santa Barbara	2	1.9%	67%	1.5%
St. Barnabas	9	8.3%	60%	7%
West Adams	2	1.9%	100%	1.5%
Field	31	28.7%	N/A	23%

74 of the total 108 respondents (69%) access PHI and/or sensitive data for their work.
Percent of Respondents Who Access Sensitive Information and/or PHI



Departments Represented by Respondents

- Communications/Marketing
- Contact Center
- Development
- Finance

- Health Services
- Health Self-Management Services
- Interns
- Strategic Initiatives/Contracts/Network/Quality Assurance
- Operations/Administration/Leadership
- Volunteers

Types Sensitive Information Handled by Partners Staff

- Client Diagnosis
- Client Contact Information (Name, Address, Phone, Email)
- Client Financial Status
- Client Legal Status
- Background Checks, Criminal Records, Sex Offender Status
- Medical Eligibility
- Client Eligibility

Suggestions for QAPI and Exec Team

The PIP Team's recommendations are categorized into three main areas for improvement; 1) education, 2) policies and procedures, 3) and IT support for satellite offices. The following are presented with the issues identified, recommendations for improvement and the suggested responsible department for implementing the recommendations. This survey should be repeated once per year to measure and maintain quality and inform continuous strategies for performance improvement related to the handling of PHI and other sensitive information as it relates to the agencies' partners, clients and employees. The PIP Team suggests this be considered for discussion in the upcoming QAPI Committee on March 17, 2016 and that the QAPI Committee advances further recommendations to the Exec Team and CEO for organization-wide implementation.

Education

Issue to Address	Recommendation	Dept. Responsible for Implementation
1. Lack of understanding on appropriate ways to handle PHI and sensitive information.	Create a FAQ's sheet or "Do's and Don'ts" on PHI to educate staff on best practices for handling PHI. Ensure all staff have HIPAA and IT security training.	QAPI HR
2. Lack of understanding on what is considered PHI vs. sensitive information.	Ensure all staff has a clear definition of PHI and sensitive information and understand what actions need to be taken when handling this information. Should be included in Partners HIPAA/PHI policy and should also be a 1-sheet that can be included as an attachment to FAQs. CEO should send FAQs and 1-sheet as a memo to all staff.	QAPI/Exec Team

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MSSP PERFORMANCE IMPROVEMENT PROJECTS
2015 through 2017

		CEO
3. Confusion on how/when to send secure emails and fax and print securely.	Develop IT refresher training showing staff how and when to use secure email/print/fax functionality.	IT
4. Lack of knowledge of where to shred documents.	Ensure all staff has knowledge of shredder locations and understand what kinds of documents need to be shredded. Could create signage in common printing areas.	Admin/Operations/QAPI

Policies and Procedures

Issue to Address	Recommendation	Dept. Responsible for Implementation
1. Some staff members do not utilize passwords for work stations, laptops and phones.	Review Partners' Password policy to ensure it is aligns with security policies and provides recommendations for creating, remembering and changing passwords.	QAPI/Exec Team
	Review Mobile Devise Use policy to ensure it addresses security. Ensure staff has knowledge of password use for work station, laptops and phones. Can send a refresher memo.	QAPI IT
2. Lack of use of privacy screens on computers.	Inventory staff needs for privacy screens and ensure appropriate staff are issued screens and receive education on appropriate use of them.	Exec Team/IT
3. Lack of standard procedures being followed with documents containing PHI in the field.	Ensure field staff has necessary equipment with locks to maintain documents in the field. Ensure policy is in place that explains requirements for handling documents in the field.	Exec Team QAPI/Exec team

IT Support for Satellite Offices

Issue to Address	Recommendation	Dept. Responsible for Implementation
1. Staff in Partners satellite offices does not have immediate access to in-person IT support.	Implement (or add to existing) policy to require IT response to satellite offices within 24hr.	QAPI/Exec Team
2. Remote IT access program only allows for 5-minute intervals of connectivity. Interrupts IT support time and extends time it takes to solve problems. Interrupts workflow.	Consider training one admin staff member in each office in basic IT to be able to support staff in absence of an IT staff member.	IT/Exec Team

	Purchase a more efficient program for remote access that allows for longer connection time.	Exec Team/CEO

QI Projects 2-5 all focus on specific aspects of MSSP service provision, monitoring, and client satisfaction. Each is led by one improvement advisor and supported by a team of project, front-line and advisory staff, and project sponsors.

QUALITY IMPROVEMENT PROJECT #2: Initiated May 2016, active and on-going.

Project Name: Improved Management of MSSP Quality Improvement Reports (QIRs)

SMART GOAL: Reduce the amount of time it takes to resolve quality improvement reports from the MSSP from greater than 60 days to 14 days or less by Oct 30 2016, but developing a systematic process of resolving quality improvement reports. Reduced time will be measured by date reported compared to date resolved.

Problem Statement: Prior to NCQA accreditation, MSSP processed and resolved incidents/complaints within the Health Services Department. Post accreditation, PICF developed a quality improvement reporting system that would be used agency wide. Since the development of the systems, there developed a gap of information between when or how incidents that were reported were resolved and some incidents lingered without resolution or for longer than 60 days.

Project Status: As of 10-19-16 approximately 15 QIR's have been reviewed, and of those 15, incidents have been resolved and closed in the targeted time frame of 14 days or less. Quality improvement reports are submitted from 4 different MSSP sites across three counties, from central California through LA County and from a client population of approximately 975, an employee population of approximately 35, a volunteer population of 10 interns, and a vendor population of approximately 70 vendors. Since October, the Improvement Advisor is working with the Human Resources Department and the Improvement Advisor of the Falls Event Reporting Project (detailed below) to coordinate one integrated Quality Improvement Reporting process for MSSP that integrates not only the operational and procedural incidents being reported, but also the new Falls Reporting Process that has been established in QUALITY IMPROVEMENT PROJECT #4 OF THIS SUMMARY. It is the QAPI Committee plan for 2017 to roll out a revised and improved QIR process agency-wide based on QI Projects 1 through 4.

QUALITY IMPROVEMENT PROJECT #3: Initiated May 2016, active and on-going.

Project Name: Improved Durable Medical Equipment Authorization Process

Smart Goal: Increase client's safety by reducing the amount of time for the Multipurpose Senior Service Program (MSSP) to be notified if Durable Medical Equipment (DME) will be approved or denied by health plan from greater than three (3) months to 6 weeks or less.

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Problem Statement: MSSP and the health plans need to be aligned in the coordination of care as outlined by the Department of healthcare Services/California Department of Aging to comply with the Coordinated Care Initiative. The delays of receiving DME can put client's safety at risk. The need to standardized processes will help to identify the barriers to effective provisioning and to establish a mechanism with two health plans to identify breakdowns in their current processing methods and make process improvements that reduce approval time and eliminate lost approval forms and documents.

Barriers identified in the assessment phase included:

1. Length of time from request to authorization or denial;
2. Need to make repeated calls to pharmacies;
3. The discovery of lost DME requests;
4. The number of repeated contacts with Health Plans to follow up on the status of DME requests;
5. Unreturned phone calls from authorizing physicians;
6. Referrals forms not received by authorizing physicians.

Project Status: The ordering of DME for MSSP sites North and South is now being managed through steps defined by Health Plan procedures and practices which were instituted when the Coordinated Care Initiative was implemented in late 2015. The procedures under these agreements require different handling of DME requests and subsequent authorization paperwork submission by primary care physicians which are then submitted to Health Plans for eligibility review, approval or decline. These new steps represent a significant departure from the past 10 years of MSSP practice under State guidelines; resulting in delays occurring in the acquisition of assistive devices needed by MSSP clients and this has added a new risk management factor for MSSP staff to manage and problem solve.

This project is still on-going and will be supported and guided by the QAPI Committee to completion, the review of critical findings, and implementation of recommendations.

QUALITY IMPROVEMENT PROJECT #4: Initiated June 2016, Completed Dec 2016. Ongoing monitoring.

Project Name: Telephonic Client Satisfaction Survey Administration

Smart Goal: Reduce client satisfaction survey administration and data collection/analysis timeframe from 4-5 months to 1-2 months. Increase survey response rate by 5% by December 1, 2016 by administering the survey via telephone rather than mail.

Problem Statement: Partners in Care Foundation has followed fundamental guidelines for surveying members/clients to incorporate feedback, which have been determined by the California Department of Aging (CDA). Surveys are mailed and take 4-5 months to receive all responses and aggregate data manually. Manual data analysis increasing chance for error and delays response and follow up with clients when needs are specifically identified through the client satisfaction survey. This QI project established more internal controls on the methods and process of understanding patient experience. To achieve this, the following steps were taken:

NCQA CM 4 and CM 6
MSSP PERFORMANCE IMPROVEMENT PROJECTS
2015 through 2017

1. Revised survey questionnaire to support telephonic data gathering;
2. Development of a script, survey methods and data collection guidelines;
3. Trained call center staff on survey administration and data collection system;
4. Implemented electronic survey software for immediate data collection and automated downloading and reporting of data;
5. Daily and weekly reports on survey administration progress and data collected.
6. Management of data and reporting by Director of Quality and Metrics.

Key Changes Applied: MSSP Client Satisfaction Survey, which has historically been mailed out annually to active clients or clients who have be active within the last 90 days, was administered as a phone survey using online survey data collection software. This allowed for quicker response time, increase survey response rate and quicker identification of client needs/concerns. Phone calls were conducted by the agency's call center staff and data was automatically aggregated in the online survey software, eliminating the need for MSSP Supervisors to manually aggregate survey responses.

Key Assumptions:

- Phone/web-based surveys are more efficient than mail.
- Call Center can provide dedicated staff (key enablers) and dedicated time (specific dates and total hours) to prioritize surveys.
- MSSP Program Supervisors could provide list of clients to survey.
- Care Managers could alert clients of upcoming surveyors to prepare for non-program staff to make calls.
- Call Center Manager would support sustainability plan.
- Program supervisors would collaborate and support survey administration plan.

Project Outcomes: Reached survey response rate goal in 2 weeks of implementation compared to 4-5 months prior to intervention. Reduced staff time and cost associated with MSSP Supervisors manually aggregating data by using a web-based system to automatically aggregate data in preparation for analysis. Reduced staff costs with hourly call center staff conducting surveys and eliminated mailing costs associated with surveys.

Key Improvement Metrics and Results:

** Staff Time Reduced Supervisor staff time on surveys by using Call Center staff.

**Response Rate Response rate increased for pilot site with previous year's data.

**Survey Administration Time averaged out at approximately 10 minutes per survey. Goal reached in approximately 2 weeks.

QUALITY IMPROVEMENT PROJECT #5: Initiated May 2016, Completed Dec 2016, Awaiting finalization. Ongoing monitoring.

Project Name: MSSP Client Falls Event Reporting, Tracking, and Management

NCQA CM 4 and CM 6
MSSP PERFORMANCE IMPROVEMENT PROJECTS
2015 through 2017

Smart Goal: Increase the completion rate of MSSP Client Falls Event Reports [QIR] using self-reported information gathered during telephonic or face-to-face visitation from a population of approximately 327 patients who live independently. Using baseline falls event data from the Bakersfield, North and South MSSP sites collected over a 90-day period between January and March of 2016, the pilot process will improve falls event reporting, at the Santa Barbara and Bakersfield sites by 30% over the baseline measure, in a 90-day period between August 29 and November 29, 2016.

Key Assumptions	Patient falls occur and are either under reported or not reported at all. This deficit creates a barrier to providing the best care possible and inhibits staff of the MSSP program in achieving the highest quality outcomes that could be provided by program interventions.
Key Enablers	• Use of simple electronic tools that made rapid deployment of project procedures inexpensive and actionable. • High degree of cooperation from QA Department staff and Program staff.
Sustainability Plan	• Routine and impromptu status briefings with Site Supervisors. • Using GoToMeeting Training Sessions to teach new staff and to provide status updates to the participating teams who were in two different remote locations from the IA.

Key Changes Applied:

- ✓ Use of standardized fall screening questions.
- ✓ Using guidelines that prompted progress notes to correspond and support event reports.
- ✓ Standard work processes that promoted care team conversations to review report findings and implications for added care interventions.
- ✓ Providing regular updates to front-line staff allowing them to see the positive results and impact of their participation in the Rapid Improvement Cycle Project.
- ✓ Establishing simple tools and steps that allow for assumptions of underreporting to be overcome and not sustained as a barrier to achieving evidenced-based care planning and service delivery.

30% above baseline	41 Event Reports Submitted, 100% improvement above baseline
Fall events reviewed in weekly care planning meetings	36 fall events were discussed; 5 other events reviewed with Site Supervisors

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MSSP PERFORMANCE IMPROVEMENT PROJECTS
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Fall types and locations reported	33 falls occurred at home/3 not at home; 5 other events occurred at home
Fall results with injury or without injury	10 falls with injury including fractures, skin tears, bruising, swelling, and pain; 26 without.

Project Outcomes: 41 Event Reports were submitted by staff from 2 sites. There were 33 falls at home, 3 not at home; 5 other types of illness reports submitted. 10 injuries occurred with 6 hospitalizations, 9 ER visits; 9 falls involved bathtub space. 36 of fall events were discussed in weekly care team meetings; the 5 other events were reviewed with the Site Supervisors. Phase 2 of this project will be managed through the QAPI Committee and plans include spreading the process during 2017 to MSSP North and South sites and integrating all tools and analytics through the new GET CARE electronic records system.

National Committee for Quality Assurance (2016)— Checklist for NCQA Data Analysis

CHECKLIST FOR NCQA DATA ANALYSIS

Complete checklist to assess comprehensiveness of NCQA reports requiring analysis.

Title of Report Assessed: _____

Date Assessed: _____

NCQA definitions:

- Quantitative analysis: A comparison of numeric results against a standard or benchmark trended over time, using charts, graphs or tables. Unless specified, tests of statistical significance are not required, but may be useful when analyzing trends.
- Qualitative analysis: An examination of deficiencies or processes that may present barriers to improvement or cause failure to reach a stated goal. Also called a causal, root cause or barrier analysis. The analysis involves those responsible for the execution of the program.

Instructions:

Enter a checkmark in the first column (√) to indicate the report meets the specific Criteria.

Complete the **Assessment Gaps & Comments** column, to document gaps (criterion is not met) as well as other feedback.

Tool is designed for use by Business Owners/Report Writers and/or Accreditation Team.

√	Criteria	Assessment Gaps & Comments
	Comparison of results with a goal or benchmark, including drawing a conclusion is required and present. • Appropriate use of mathematics, logic and statistics to draw an appropriate conclusion. • Reporting results is not enough. • Without conclusions, the numbers are simply "reporting" results. • Data analysis precedes the development and implementation of interventions.	
	QUANTITATIVE ANALYSIS	
	Comparison of results with a goal or benchmark, including drawing a conclusion is required and present. • Appropriate use of mathematics, logic and statistics to draw an appropriate conclusion. • Reporting results is not enough. • Without conclusions, the numbers are simply "reporting" results.	
	Answers the question, "What do the results (numbers) mean?" • What is happening? • How do the current results compare to prior measurement periods/results? - Getting better? Worse? • Has the goal been reached? • Is the change statistically significant? - Not required, but often helpful • Is the analysis brief and to the point?	
	Goals or benchmarks are present: • Goal (or objective): Set by organization indicating desired level of performance. • Benchmark: Best of the best based on actual performance, cannot be "set". • Threshold: Minimum acceptable performance. Usually identifies the need for intervention.	

	Minimum written conclusion requirements
	• Comparison to goal or benchmark (for both initial measurements and subsequent measurement periods).
	• Comparison to prior measurement periods
	• Draw a conclusion or conclusions
	– Writer summarized in a narrative if the goal/benchmark was met or not met. Surveyor should not be left to determine conclusion.
	  • Concludes if the last performance results have improved from the baseline.
	  • Concludes if the change is statistically significant, if applicable.
	  • Concludes if the current performance does not meet the goal
	  • Conclusion must be appropriate to the data present.	

√	Criteria	Assessment Gaps & Comments
	QUALITATIVE ANALYSIS	
	Answers the question, "Why are the results what they are?" • What are the drivers of the results? • Identifies items impacting results such as - Systems - Processes - People—staff, practitioners, members, etc. - Equipment • Focus on causes of current performance - Barriers as well as positive drivers	
	Quantitative analysis demonstrates no opportunities for improvement; what's next? • If there is no reasonable opportunity for improvement (i.e. the goal is reasonable and it has been met), qualitative analysis may not be necessary. • Determine if assessment that no opportunity exists is appropriate conclusion?	
	Participants in analysis are identified in the report • Examples: committee, department, medical director, team, manager or director. • Are they appropriate to conduct the assessment? • What was the process for the analysis?	
	OPPORTUNITIES FOR IMPROVEMENT, IF APPLICABLE	
	When Opportunities for Improvement requirements are present, reporting should include: • Identification of opportunities for improvement • Prioritization and selection of opportunities to improve • Identification of interventions based on the selection • Implementation of interventions • Measurement of effectiveness of the intervention	
	Interventions identified are: • Actions based on the causes of performance identified during qualitative analysis. • Illustrating a logical connection between an intervention and an identified cause of performance. • Reducing or mitigating a barrier or root cause. • Amplifying or enhancing a driving force.	

√	Criteria	Assessment Gaps & Comments
	NCQA does not consider the following as interventions: • Changes in methodology - Improving data collection - Changing data collection methodology - Increasing sample size - Shortening a survey to improve response rate • Continued monitoring • Further measurement • Drill-down analysis • Intent to develop a form • Developing a process change without implementing it • Scheduling a meeting • Forming a group to do further study **Confirm these actions are not labeled as interventions within the report.**	
	OPTIONAL: Participants in Intervention development and implementation are identified in the report	
	Improvement is present on Remeasurement. • An improvement in performance needs to be reasonably linked to the intervention for it to "count" as an improvement. • ALL re-measurements require narrative of how the data is trending over time.	
	FINAL Assessment: Surveyors evaluate the following: • Is there credible analysis that identifies likely causes? • Has the organization implemented interventions to specifically address (at least some of the causes?) • Are the targeted causes ones that are likely to affect measured performance? • Are the interventions robust? • Were the interventions timely? **Does this report answer "YES" to these questions?**	

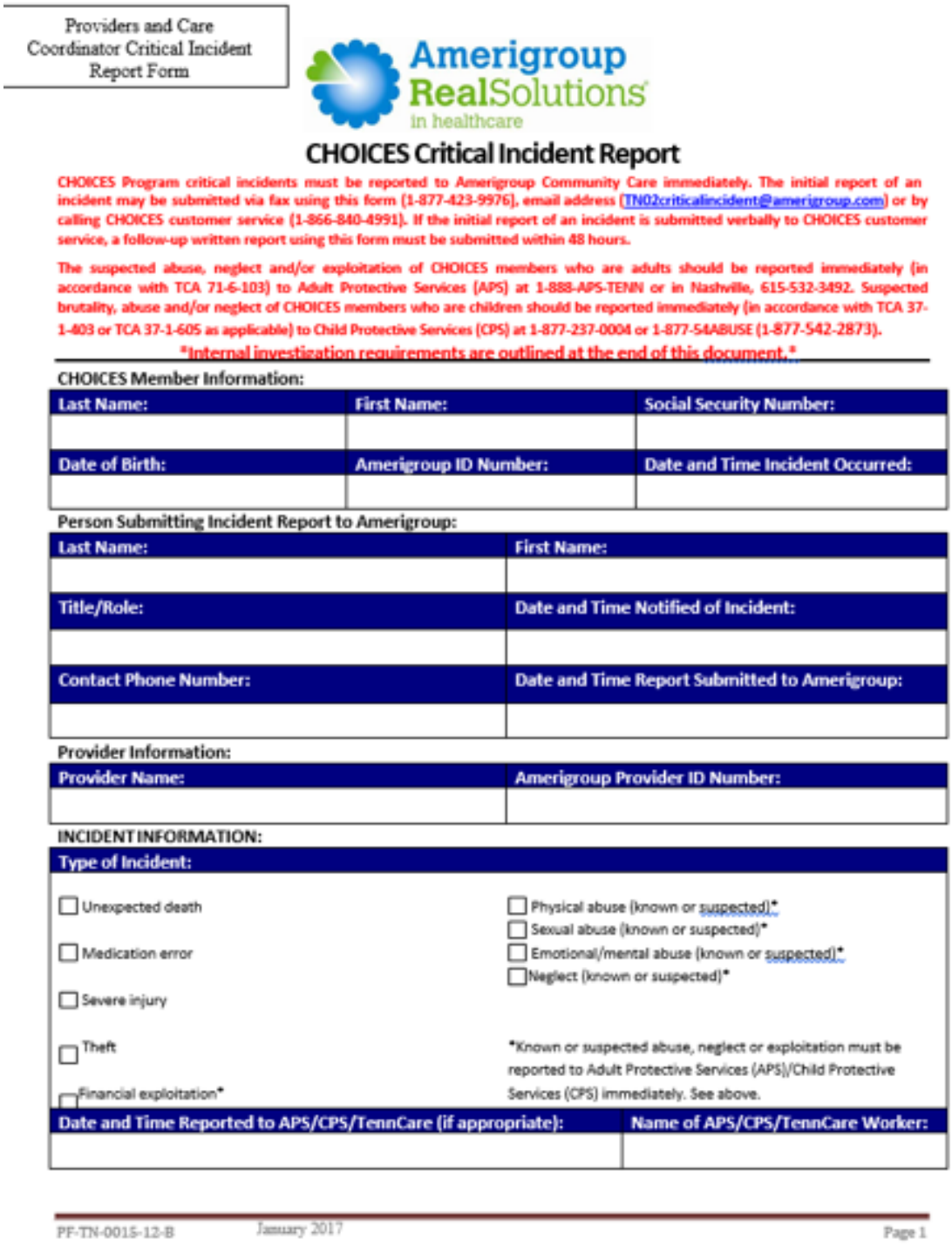
Checklist Application

Listed below are elements the Checklist may be used to assess data analysis content.

2016/2017 Standard Years	Element Name
QI 4 A	Member Services Telephone Access
QI 4 B	Behavioral Healthcare Telephone Access Standards (if applicable)
QI 4 C	Member Experience: Annual Assessment
QI 4 D	Member Experience: Opportunities for Improvement
QI 4 E	Member Experience: Annual Assessment of Behavioral Healthcare & Services
QI 4 F	Member Experience: Behavioral Healthcare Opportunities for Improvement
QI 4 G	Member Experience: Assessing Experience with the UM Process
QI 5 I	Complex Case Management—Experience with Case Management
QI 5 J	Complex Case Management—Measuring Effectiveness
QI 5 K	Complex Case Management—Action and Remeasurement
QI 6 I	Disease Management—Experience with Disease Management
QI 6 J	Disease Management—Measuring Effectiveness
QI 7 D	Practice Guidelines—Performance Measurement (applicable to First Surveys only)
QI 8 A	Continuity & Coordination (CoC) of Medical Care—Identifying Opportunities
QI 8 B	CoC Medical Care—Acting on Opportunities
QI 8 C	CoC Medical Care—Measuring Effectiveness
QI 9 A	CoC Between Medical Care and Behavioral Healthcare—Data Collection
QI 9 B	CoC Between Medical Care & Behavioral Healthcare—Collaborative Activities
QI 9 C	CoC Between Medical Care & Behavioral HealthCare—Measuring Effectiveness
NET 1 A	Cultural Needs & Preferences
NET 1 B	Practitioners Providing Primary Care
NET 1 C	Practitioners Providing Specialty Care
NET 1 D	Practitioners Providing Behavioral Healthcare
NET 2 A	Access to Primary Care
NET 2 B	Access to Behavioral Healthcare
NET 2 C	Access to Specialty Care
NET 3 A	Assessment of Member Experience Accessing the Network
NET 3 B	Network Adequacy: Opportunities to Improve Access to Non-Behavioral Healthcare Services
NET 3 C	Network Adequacy: Opportunities to Improve Access to Behavioral Healthcare Services
NET 4 C	Exchange Member Experience
NET 4 D	Exchange Member Experience Opportunities for Improvement
UM 2 C	Consistency in Applying Criteria
RR 4 C	Assessing Member Understanding
MEM 4 C	Pharmacy Benefit Information: QI Process on Accuracy of Information
MEM 5 C	Personalized Information on Health Plan Services: Quality & Accuracy of Information
MEM 5 D	E-Mail Response Evaluation

Appendix E. Rights and Responsibilities

NCQA Implementation Timeline and Survey Look-Back



Providers and Care Coordinator Critical Incident Report Form

Amerigroup RealSolutions in healthcare

CHOICES Critical Incident Report

CHOICES Program critical incidents must be reported to Amerigroup Community Care immediately. The initial report of an incident may be submitted via fax using this form (1-877-423-9976), email address (TN02criticalincident@amerigroup.com) or by calling CHOICES customer service (1-866-840-4991). If the initial report of an incident is submitted verbally to CHOICES customer service, a follow-up written report using this form must be submitted within 48 hours.

The suspected abuse, neglect and/or exploitation of CHOICES members who are adults should be reported immediately (in accordance with TCA 71-6-103) to Adult Protective Services (APS) at 1-888-APS-TENN or in Nashville, 615-532-3492. Suspected brutality, abuse and/or neglect of CHOICES members who are children should be reported immediately (in accordance with TCA 37-1-403 or TCA 37-1-605 as applicable) to Child Protective Services (CPS) at 1-877-237-0004 or 1-877-54ABUSE (1-877-542-2873).

Internal investigation requirements are outlined at the end of this document.

CHOICES Member Information:

Last Name:	First Name:	Social Security Number:
Date of Birth:	**Amerigroup ID Number:**	**Date and Time Incident Occurred:**

Person Submitting Incident Report to Amerigroup:

Last Name:	First Name:
Title/Role:	**Date and Time Notified of Incident:**
Contact Phone Number:	**Date and Time Report Submitted to Amerigroup:**

Provider Information:

Provider Name:	Amerigroup Provider ID Number:

INCIDENT INFORMATION:

Type of Incident:

- ☐ Unexpected death
- ☐ Medication error
- ☐ Severe injury
- ☐ Theft
- ☐ Financial exploitation*
- ☐ Physical abuse (known or suspected)*
- ☐ Sexual abuse (known or suspected)*
- ☐ Emotional/mental abuse (known or suspected)*
- ☐ Neglect (known or suspected)*

*Known or suspected abuse, neglect or exploitation must be reported to Adult Protective Services (APS)/Child Protective Services (CPS) immediately. See above.

Date and Time Reported to APS/CPS/TennCare (if appropriate):	Name of APS/CPS/TennCare Worker:

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INCIDENT INFORMATION (continued):

Location (address) and Setting of Incident (room, indoor/outdoor, etc.):	Other Individuals/Witnesses Involved	
	Name:	Contact Number:

Incident Description:

Please describe in detail the events that took place leading up to, during and after the incident. Please provide as much information as possible (use additional pages if necessary):

Additional Needs

Is the CHOICES member subject to further harm or does he or she have further emergency needs at this time?

☐ No ☐ Yes

If Yes, please explain:

_____

_____

_____

Internal investigation requirements:

1) Completed internal investigation documentation must be submitted to the Amerigroup Quality Management department (fax 1-877-423-9976) within 20 days after the date of the incident except under extenuating circumstances, in which case the submission must occur within no more than 30 days.
2) Details must include:
   a. Statement by the CHOICES member, family and/or CHOICES member representative
   b. Statement by the accused worker
   c. Findings of the allegation
   d. Reassignment of the accused worker to other CHOICES members
   e. Assignment of a replacement worker to the CHOICES member during the investigation

Providers and Care Coordinator Investigation Form

CHOICES Critical Incident Investigation Report

Please note: Completed internal investigation documentation must be submitted to the Amerigroup Community Care Quality Management department (fax 1-877-423-9976) and Email Address tn02ctiticalincident@amerigroup.com within 20 days after the date of the incident except under extenuating circumstances, in which case submission must occur within no more than 30 days.

CHOICES Member Information:

Last Name:	First Name:	Social Security Number:
Date of Birth:	**Amerigroup ID Number:**	**Date and Time Incident Occurred:**

Person Submitting Internal Investigation Report to Amerigroup:

Provider Name:	Amerigroup Provider ID Number:
Person Completing Report (Include Title/Role):	**Date Submitted to Amerigroup:**
Contact Phone Number:	

Incident Information:

Type of Incident:

- ☐ Unexpected death
- ☐ Medication error
- ☐ Severe injury
- ☐ Theft
- ☐ Financial exploitation*
- ☐ Physical abuse (known or suspected)*
- ☐ Sexual abuse (known or suspected)*
- ☐ Emotional/mental abuse (known or suspected)*
- ☐ Neglect (known or suspected)*
- ☐ _____

*Known or suspected abuse, neglect, or exploitation must be reported to Adult Protective Services (APS)/Child Protective Services (CPS) immediately. See above.

Date and Time Reported to APS/CPS/TennCare (if appropriate):	Name of APS/CPS/TennCare Worker:

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CHOICES Critical Incident Investigation Report **Page 2**

Internal investigation requirements:

- Completed internal investigation documentation must be submitted to the Amerigroup Quality Management department (fax 1-877-423-9976) within 20 days after the date of the incident except under extenuating circumstances, in which case the submission must occur within no more than 30 days.
- Details must include:
  1) Statement of the CHOICES member, family and/or CHOICES member representative
  2) Statement of the accused worker
  3) Findings of the allegation
  4) Reassignment of the accused worker to other CHOICES members
  5) Assignment of a replacement worker to the CHOICES member during the investigation

Internal Investigation Details:

PF-TN-0014-12 January 2017

Appendix F. General Materials

NCQA Implementation Timeline and Survey Look-Back

NCQA IMPLEMENTATION TIMELINE AND SURVEY LOOK-BACK | 2015-2017

Table 1. MONTH-BY-MONTH PLAN OF ACTION ["POA"]

Project Activity	Month																								
	1 MY '15	2 JU	3 JUL	4 AU	5 SE	6 OC	7 NO	8 DE	9 JA '16	10 FE	11 MR	12 AP	13 MY	14 JU	15 JUL	16 AU	17 SE	18 OC	19 NO	20 DE '16	21 JA '17	22 FE	23 MA '17	24 AP	25 MY	26 JU
1. Establish NCQA Team Work Plan	X																								
2. Finalize NCQA PI Plan a. Review and Revise	X	X																X	X	X					
3. HS Programs Gap Analysis			X	X																					
4. All-Program Metrics Spreadsheet	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
5. CM 10, 10.1 and 10.2: Drafted, Reviewed, Finalized [ON HOLD AS OF 5-26-2015]		X	X	X	X																				
6. Technology/Applications Evolution Tracking	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
7. Organization-wide QA Plan			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
8. NCQA **Incident Reporting:** process, terminology, tools, training, small starting projects (PHI PIP, KP Projects)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

NCQA IMPLEMENTATION TIMELINE AND SURVEY LOOK-BACK 2015-2017

a. Tracking																									
Project Activity	Month																								
	1 MY '15	2 JU	3 JUL	4 AU	5 SE	6 OC	7 NO	8 DE	9 JA '16	10 FE	11 MR	12 AP	13 MY	14 JU	15 JUL	16 AU	17 SE	18 OC	19 NO	20 DE '16	21 JA '17	22 FE	23 MA '17	24 AP	25 MY	26 JU
9. Training/Tracking Process Comprehensive Spreadsheet		X	X	X	X	X	X	X	X	X	X	X	Xx[iii]	Xx	Xx	X	X	X	X	X	X	X	X	X	X	X
10. CM 1-9 Revisions by Program ***[MSSP ONLY=KEEP IN CURRENT FORMAT/TEMPLATES]***		X	X	X	X	X							X	X	X	X[iii]	X	X[iv]	X[v]							
11. All Staff Meeting/August 2016	X	X	X													X										
12. Communications Plan a. Key Contacts (Ltr from June) --Intervals/type of content --Emergent issues --QAPI website launch	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
13. Quality Methodology Selection + Implementation a. KP IA methodology	X	X	X	X	X	X	X	X	X	X	X a.	X a.	X a.	X a.	X a.	X a.	X a.	X a.	X a.	X a.	X a.	X a.	X a.	X a.	X a.	X a.
14. Initiate NCQA PI/QA Multi-site Monitoring Team		X																								
15. Complete Baseline Measurement by 12/12/15								X																		

NCQA IMPLEMENTATION TIMELINE AND SURVEY LOOK-BACK | 2015-2017

a. PHI PIP																									
16. EE All Staff Meeting: roll out PDSA [REVIEWED IN QAPI] a. KP project kick-off meetings			X										X	X											
17. P-P Naming nomenclature and conventions	X	X	X	X	X	X	X	X																	
Project Activity	Month																								
	1 MY '15	2 JU	3 JUL	4 AU	5 SE	6 OC	7 NO	8 DE	9 JA '16	10 FE	11 MR	12 AP	13 MY	14 JU	15 JUL	16 AU	17 SE	18 OC	19 NO	20 DE '16	21 JA '17	22 FE '17	23 MA '17	24 AP	25 MY	26 JU
18. QA budget a. Financial analysis; draft listing of project costs and rough estimate of labor costs																									
19. Tracking of Incident Reports; CAP's [MSSP/CUST SAT+MILEAGE REPORTING]			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
20. Tracking of P-P Revision Dates; Implementation of new P-P			X	X	X	X	X	X	X	X	X	X[vi]	X	X	X	X	X	X	X	X	X	X	X	X	X	X
21. NCQA Re-Survey App for2017; uploading; Question response												X	X	X	X	X	X	X	X	X	X	X	X	X	X

*Some activities may be outside the scope of CM required Standards but related to NCQA product development activities.

NCQA IMPLEMENTATION TIMELINE AND SURVEY LOOK-BACK 2015-2017

Project Activity	Month																									
	1 MY '15	2 JU	3 JUL	4 AU	5 SE	6 OC	7 NO	8 DE	9 JA '16	10 FE	11 MR	12 AP	13 MY	14 JU	15 JUL	16 AU	17 SE	18 OC	19 NO	20 DE '16	21 JA '17	22 FE '17	23 MA '17	24 AP	25 MY	26 JU
22. Emergency Preparedness MSSP Staff Review; sign off; drill?																					X	X				
23. Get Care test runs; chart review; alerts testing																					X	X				
24. Complete readiness checklist steps; 60-day pre-site survey																				X	X	X				
25. QIR monthly metrics reports; CEO and QAPI reviews															X	X	X	X	X	X	X	X	X	X	X	X

[i] **PIP-PHI** Recommendations for training and action steps to be implemented and monitored by QAPI Team; May through July 2016
[ii] **CM 9** to be reviewed and revised and loaded into NCQA ISS Tool; this action step to be aligned with roll out of PIP PHI Rec's and training; monitored by QAPI Committee; May-July 2016
[iii] **CM 8** to be reviewed and revised including translation into required languages; monitored by QAPI Committee; August-September 2016
[iv] **CM 6** to be reviewed and revised; to include content covering QAPI, IR, KP-II IA Projects, NCQA required reporting of CAP's during 2015/MSSP, QA Director/Metrics; PIP/PHI, others; October- November 2016
[v] **CM 4,5** to be reviewed and revised; to include MSSPCare Event reporting and analysis; November-December 2016
[vi] **CM's 1,2,3,** and **CM 7** to be reviewed, finalized, and loaded into NCQA ISS Tool; monitored by QAPI Committee; April through June 2016

PARTNERS POLICY AND PROCEDURES REVISIONS ACTIVITIES:

NCQA IMPLEMENTATION TIMELINE AND SURVEY LOOK-BACK | 2015-2017

For MSSP P/P, the revisions will be made using any required CA/DOA updates and guidelines as well as the NCQA Survey Recommendations of 2015. The NCQA ISS Survey Tool Documents archived in the ISS Library will be utilized during all P/P revisions and edits; approximately 100 Partners documents are archived at the time of application and uploaded on 1/6/2015; all documents from this library list will be reviewed, revised, deleted. QAPI Committee Members, MSSP Staff, and other assigned PICF staff will be scheduled to participate in the document reviews and editing.

TABLE COLOR KEY:

Yellow=NCQA on site readiness preparation and survey visit.

Bright Green=Time periods of NCQA active measurement

Light Green=P/P targeted months for assigned policy reviews and revisions

Violet=MSSP Program-specific P/P reviews and revisions

Red=60 days, pre-site visit; survey upload

TO BE SCHEDULED: QAPI Review and CEO Sign Off for all P/P's finalized for ISS Survey Upload.

60-day pre-survey readiness checklist

1. Create Binders
2. Train key staff; communicate revisions where applicable
3. Pull out revised and obsolete P/P's=archive them; transmit communication to all staff/MSSP staff on access and updates/where to locate/how to locate
4. Brief Administrative Team/Exec Team on Org-wide QA Objectives
5. Conduct tracer rounding
6. Conduct chart audits
7. Quality Improvement Report binder; HR log; Insert KP Falls Project event report analysis documentation with Survey Gizmo doc's

DRAFT #1 5/6/2015; UPDATED 5/26/2015
UPDATED 6/30/2015; UPDATED 4/18/2016
UPDATED 12/29/2016

NCQA IMPLEMENTATION TIMELINE AND SURVEY LOOK-BACK | 2015-2017

8. Personnel records review
9. Business license [submitted with reapplication?]
10. TIN status [submitted with reapplication?]
11. MSSP state contract [where is it located? When last renewed?]
12. NCQA Attestations=CAP's, proof of sustainability
13. Org chart
14. Strategic plan, vision, mission
15. Proof of emergency drill
16. Implement CDHS multi-language client rights handout
17. Update month-by-month POA, add new dates for all P&P revisions
18. MSSP Home and Community Based settings survey to be released end of Jan. 2017. Incorporate into MSSP QA plan
19. Review any acuity rating systems in Partners programs

NCQA Library Document Tracking

CM Standard - Element	Document Name	File Path	Notes	Date Attached	Reference Pages	Relevance	Staff Responsible	Revisions Due
Not Linked	CM File Review Results.xls	CM File Review Results.xls.xlsm						
Not Linked	cred file review results.xls	cred file review results.xls.xlsm						
CM1 - A	HomeMeds JAGS Article	1 Vanderbilt RCT Meredith.pdf			All	Supporting		
CM1 - A	MSSP CM 1	2014-12-21 PICF CM 1.docx			All	Primary		
CM1 - A	MSSP CM 1Narrative	MSSP CM1 Narrative FINAL.docx			All	Primary	Marcia and Tahirah	
CM1 - A	MSSP Site Manual Chapter 3	MSSP Chapter_3.docx	Cross check page numbers		Sect. 3.100 p4; 3.110 p5; 3.130 p8; 3.140 p11; 3.150 p11	Secondary		
CM1 - A	MSSP Zip Code Lists	Zip Code List revised - South.doc	need to get revised lists (North, South, Kern and santa Barbara)		All	Secondary	Hugo	
CM1 - A	Partners Caregiver Programs	Partners Caregiver Broch 2014 7.pdf	Will remain, but need to ensure that it's up-to-date		All	Supporting	Check with Sherry	
CM1 - A	Partners MSSP Brochure	MSSP.Broch.201	have updated brochure		All	Supporting	Communicatio	
CM1 - B	MSSP CM 1	2014-12-21 PICF CM 1.docx			1-2	Primary		
CM1 - B	MSSP CM 1 Program Narrative	MSSP CM1 Narrative FINAL.docx			5-7	Primary	Marcia and Tahirah	
CM1 - C	2014-05-15 Staff Meeting	22014-05-15 Staff Meeting.pdf	Need newer documentation on this; Finding Staff Meeting that addresses programs and content.		All	Secondary	Aloyce may have documents for South, Melissa has for North. Request agenda and documents from Supervisors meeting on Nov 17, 2015 where CCI is discussed.	
CM1 - C	2015-01-29 Cultural Sensitivity Inservice	20145-01-29 Cultural Sensitivity Inservice.pdf	Request Update		All	Secondary	Aloyce may have from LA Care requirement	
CM1 - C	Care Planning and Coordination (Training Module)	CDA-CCI_MSSP_Module_3_Care_Planning_and_Coordination.ppt	Combining this content		All	Secondary	check with Melissa for list of trainings done in past year. Choose 1-2 that are relevant.Use blood pressure training from 9/22/2016 and suicide awareness 9/9/2016, Security Awareness training on May 19th, 2016. copies of certificates from staff who completed. Emergency preparedness on May 12, 2016. Working Care Plan	

CM1 - C	CM1 Narrative HIGHLIGHTED	CM1 Narrative HIGHLIGHTED.docx			5-6	Primary	
CM1 - C	Eligibility Assessment (Training Module)	CDA CCI_MSSP_Module_2_Eligibility_Assessment.ppt	Need to ensure that it's up-to-date		All	Secondary	figure out what this document refers to. Send to Aloyce
CM1 - C	Ethnic and Linguistic Characteristics of MSSP Staff	Ethnic and Linguistic Characteristics of MSSP Staff.xlsx	Aloyce stated this has not been updated		All	Supporting	can use same document
CM1 - C	MSSP CM 1	2014-12-21 PICF CM 1.docx	Once committee reviews this, will be good to submit		p. 3	Primary	
CM1 - C	MSSP CM 1 Narrative	MSSP CM1 Narrative FINAL.docx			All	Primary	
CM1 - C	Overview of MSSP - Training Module	CDA CCI_MSSP_Module_1_Overview.ppt	Current CM1C doesn't reflect this; need new update		All	Secondary	check on what this refers to.
CM1 - C	Partners MSSP Patient Handouts	Patient Handouts.pdf	Have received some from Sandra. Ensure we have everything.		All	Supporting	new handout from Sherry on Medi-Cal and Cal Medi Connect. Already have copies
CM2 - A	MSSP CM 2	MSSP CM2 Pt ID-Assessment.docx				Primary	
CM2 - A	MSSP Site Manual	Ap_41d_NCM_T	Need to check this		All	Supporting	
CM2 - A	MSSP Site Manual Appendix 41i RO Checklist	Ap_41i_NCM-SWCM_RO_Chklst.pdf	Need to check this with MSSP to see if there were any changes		All	Supporting	no change
CM2 - A	MSSP Site Manual Appendix Medi-Cal Aid Codes	Ap_07_Medi-Cal_Aid_Codes.pdf	Reload and update		All	Supporting	no change
CM2 - A	MSSP Site Manual Chapter 1	MSSP Chapter_1.docx			Sect. 3000 p3; 3130 p3; 3110 p3	Secondary	
CM2 - A	MSSP Site Manual Chapter 2 Staffing	MSSP Chapter_2.docx			Section 2.300 p2; 2.000 p2;	Secondary	
CM2 - A	MSSP Site Manual Chapter 3	MSSP Chapter_3.docx			Sect. 3.620 p3; 3.140 p44; 3.150 p59	Secondary	
CM2 - A	MSSP Site Manual, Appendix 09 Application	Ap_09_Application.pdf	Has not changed in past 2 years.			Supporting	
CM2 - A	MSSP Site Manual, Appendix 16, LOC Certification Form	Ap_16_LOC_Certification.pdf	Has not changed in past 2 years.		All	Supporting	
CM2 - A	MSSP Site Manual, Appendix 41-f SWCM Pathway	Ap_41f_SWCM_T&D_Pathway.pdf	Need to check with Aloyce.		All	Supporting	no change
CM2 - A	MSSP Site Manual, Appendix 41g SCM Pathway	Ap_41g_SCM_T&D_Pathway.pdf	Need to check with Aloyce.		All	Supporting	no change
CM2 - B	Example Core Process Highlighted for Referrals	Example Core Process Highlighted for Referrals.ppt	Check for updates.		Left column	Supporting	
CM2 - B	Referral Summary Report	Referral Summary Report.pdf	Does this data need to be updated?		All	Supporting	check on this document
CM2 - C	MSSP Intake Form	PICF Client Intake Form	Check this form between sites.		All	Supporting	no change

CM2 - B	Example Core Process Highlighted for Referrals	Example Core Process Highlighted for Referrals.ppt	Check for updates.		Left column	Supporting	
CM2 - B	Referral Summary Report	Referral Summary Report.pdf	Does this data need to be updated?		All	Supporting	check on this document
CM2 - C	MSSP Intake Form	PICF Client Intake Form	Check this form between sites.		All	Supporting	no change
CM2 - C	MSSP Policy - Wait List	2-9-2015 MSSP Policy - Wait List.docx	Needs to be reviewed; Aloyce will be sending it. Any new CCI references will need to be added since documents are from 2014, prior to CCI.		All	Primary	Aloyce
CM2 - C	Wait List (sample)	Wait List.pdf			All	Supporting	Aloyce - ask Carolina
CM2 - D	Chapter 3 Highlighted Assessment	Chapter_3 Highlighted Assessment.pdf	CCI?		17-21	Secondary	
CM2 - D	Chapter 3 Highlighted Care Planning	Chapter_3 Highlighted Care Planning.pdf	CCI?		23-35	Secondary	
CM2 - D	Chapter 3 Highlighted Progress Notes	Chapter_3 Highlighted Progress Notes.pdf	CCI?		33-34	Secondary	
CM2 - D	Fall Prevention 7 Steps Chart	7Steps Eng 001.jpg	Received handout from Hugo		All	Supporting	Hugo
CM2 - D	Fall Prevention 7 Steps	7Steps Sp	Received handout from		All	Supporting	Hugo
CM2 - D	MSSP CM 3 Care Planning	MSSP CM 3a.docx			All	Primary	
CM2 - D	MSSP CM2 Patient ID and Assessment	MSSP CM2 Pt ID-Assessment.docx			All	Primary	
CM2 - D	MSSP Policy - Progress Notes	MSSP Policy - Progress Notes.docx	Where is Documentation policy? Need to find this and should be referenced there. As of 10/24/2016, we have this policy, but need to make sure it is up to		All	Primary	need to finalize
CM2 - D	MSSP Site Manual Appendix 18A Initial Health Assessment	Ap_18a_Initial_Health_Assessment.pdf	Does this need to be updated?		All	Supporting	same
CM2 - D	MSSP Site Manual Appendix 19A Psychosocial Assessment	Ap_19a Initial_Psychosocial_Assessment.pdf			All	Supporting	
CM2 - D	MSSP Site Manual Appendix 19d Functional Grid	Ap_19d_Functional_Needs_Assessment_Grid_-_Reassessment.pdf			All	Supporting	
CM2 - D	MSSP Site Manual Appendix 19F Cognitive Assessment	Ap_19f_Approved_Cognitive_Screening_Tools_10-2011.pdf			All	Supporting	
CM2 - D	Sample Redacted Care Plan	4 MSSP Care Plan Sample az details.pdf	Get one of these from GetCare		All	Supporting	not correct in GetCare yet. Can get from MSSP Care
CM2 - D	SPMSQ	SPMSQ.pdf	Need to spell this out. Is it an assessment?		All	Supporting	part of the psycho-social and reassment
CM2 - E	CM File Review Results	C:\Users\hawranko\OneDrive - NCQA\ASC Surveys 2015\Partners in Care\Copy of CM File Review Results.xls.xlsm			All	Primary	
CM3 - A	MSSP CM 3	MSSP CM 3.docx			All	Primary	
CM3 - A	MSSP Site Manual Appendix 22 Care Plan	Ap_22_Care_Plan.pdf	Need 2016 Update		All	Supporting	same
CM3 - A	MSSP Site Manual Appendix 22a Care Plan Instructions	Ap_22a_Care_Plan_Form_Instructions.pdf			All	Supporting	

CM3 - A	Sample Care Plan	4 MSSP Care Plan Sample az details.pdf	need update		All	Supporting	can get from MSSP Care
CM4 - A	LOC Scheduled Next Updates Form	LOC-SCHEDULED NEXT UPDATES FORM.pdf			All	Supporting	need to check on this document. MSSP does not use it. Aloyce has an excel sheet that they use to track and can print from MSSP care but
CM4 - A	MSSP CM 4	MSSP CM4.docx			page 1	Primary	
CM4 - A	MSSP Policy- Procedure on CM Processes-Staff-Timelines	MSSP Policy-Procedure on CM Processes-Staff-Timeliness.docx			All	Primary	
CM4 - A	MSSP Policy- Procedure on CM Processes-Staff-Timeliness	MSSP Policy-Procedure on CM Processes-Staff-Timeliness.docx			All	Primary	
CM4 - A	MSSP Site Manual Chapter 5	MSSP Chapter_5.docx			Section 5.810pages 9-10	Secondary	
CM4 - A	MSSP Table of CM Processes-Staff-Timeliness Standards	MSSP Table of CM Processes-Staff-Timeliness Standards.docx			All	Primary	
CM4 - A	MSSPCare Screenshot Care Plan	MSSPCare Screenshot Care Plan.pdf			All	Supporting	
CM4 - A	MSSPCare Screenshot Health Assessment	MSSPCare Screenshot Health Assessment.pdf			All	Supporting	
CM4 - A	MSSPCare Screenshot Psychosocial Assessment	MSSPCare Screenshot Psychosocial Assessment.pdf			All	Supporting	
CM4 - A	MSSPCare Screenshot Psychosocial Assessment COMMENTS	MSSPCare Screenshot Psychosocial Assessment COMMENTS.pdf			All	Supporting	
CM4 - A	MSSPCare Screenshot Reassessment	MSSPCare Screenshot Reassessment.pdf			All	Supporting	
CM4 - B	MSSP CM 4	MSSP CM4.docx			p. 2	Primary	
CM4 - B	MSSP Core Process Map	Example Client CORE_PROCESS Map MSSP.ppt			All	Supporting	
CM4 - B	MSSP Policy- Procedure on CM Processes-Staff-Timeliness	MSSP Policy-Procedure on CM Processes-Staff-Timeliness.docx			All	Primary	
CM4 - B	MSSP Process Flow	MSSP Workflow.pptx			All	Supporting	
CM4 - B	MSSP Site Manual Appendix 22 Care Plan	Ap_22_Care_Plan.pdf			All	Supporting	
CM4 - B	MSSP Site Manual Appendix 22a Care Plan Instructions	Ap_22a_Care_Plan_Form_Instructions.pdf			All	Supporting	
CM4 - B	MSSP Site Manual Chapter 3	MSSP Chapter_3.docx			Sect. 3.640 p.22-35;Sect 3.1500-1520 p59-60	Secondary	
CM4 - B	MSSP Table of CM Processes-Staff-Timeliness Standards	MSSP Table of CM Processes-Staff-Timeliness	Needs to be updated and Notice of Action needs to be in here- internals may have been adjusted. As of 10/24/2016, this has been		All	Supporting	

c							
CM5 - A	Chapter 3 - MSSP Deinstitutionalization	Chapter_3 - Deinstitutionalization HIGHLIGHTED.docx			40-44	Secondary	
CM5 - A	Chapter 3 - MSSP Transfers HIGHLIGHTED	Chapter_3 - MSSP Transfer HIGHLIGHTED.docx			62-63	Secondary	
CM5 - A	MSSP CM 5	MSSP CM 5.docx			p. 1-2	Primary	
CM5 - A	MSSP Core Process Map	Example Client CORE_PROCESS Map MSSP.ppt			All	Supporting	
CM5 - A	MSSP Site Manual Chapter 3	MSSP Chapter_3.docx			3.100 p37;3.130 p41;3.180 p63; 3.800 p33	Secondary	
CM5 - B	MSSP CM 5	MSSP CM 5.docx			2	Primary	
CM5 - C	LOC Scheduled Next Updates Form	LOC-SCHEDULED NEXT UPDATES FORM.pdf			All	Supporting	notes above
CM5 - C	MSSP CM 5	MSSP CM 5.docx			2	Primary	
CM5 - C	MSSP Site Manual Appendix 23 Institutionalization Form	Ap_23_Institutionalization_Form.pdf			All	Supporting	
CM5 - C	MSSP Site Manual Chapter 3	MSSP Chapter_3.docx			Section 3.800 p33	Secondary	
CM5 - C	MSSP Success Story	MSSP Success Story.docx	As of 10/24/2016, have an updated success story.		All	Supporting	
CM5 - C	MSSPCare Screenshot Progress Notes	MSSPCare Screenshot Progress Notes.pdf			All	Supporting	can get from MSSPCare, may be ready in GetCare
CM5 - D	2-9-2015 MSSP Policy Progress Notes	2-9-2015 MSSP Policy - Progress Notes with edits.docx			All	Primary	
CM5 - D	MSSP CM 5	MSSP CM 5.docx			2	Primary	
CM5 - D	MSSP Site Manual Chapter 3 Highlighted	Chapter_3-1_HIGHLIGHTED.pdf			3, 5, 31-33,46, 53-54, 56, 57, 59-60	Secondary	
c							
CM6 - A	MSSP CM 6	MSSP CM 6.docx			1	Primary	
CM6 - A	MSSP North Patient Satisfaction Survey Results	MSSP North Patient Satisfaction survey results.pdf	have 2015 results compiled in early 2016. can also provide Kern and Santa Barbara results		All	Supporting	
CM6 - A	MSSP Patient Satisfaction Questionnaire	Client Satisfaction Questionnaire1.doc	provide updated questionnaire		All	Secondary	
CM6 - A	MSSP Quality Assurance Program	Quality Assurance.doc			All	Primary	
CM6 - A	MSSP Site Manual Chapter 4	MSSP Chapter_4.docx			Section 4.030, p2	Secondary	
CM6 - A	MSSP South Patient Satisfaction Survey Results	MSSP_South Patient Satisfaction survey results.pdf	provide 2015 results (get from Renee and Sal)		All	Supporting	
CM6 - B	2014 Peer UR Analysis Reports	2014 Peer UR Analysis Reports.pdf	Need updated reports		ALL	Supporting	in a binder in Aloyce and Melissa
CM6 - B	CDA UR HIGHLIGHTED	CDA UR_HIGHLIGHTED.pdf			ALL	Supporting	
CM6 - B	MSSP CM 6	MSSP CM 6.docx			2-3	Primary	
CM6 - B	MSSP CM 6.1 Policies & Procedures	CM6-1 Policy Development			All	Primary	
CM6 - B	MSSP Internal Peer Review Form	Peer UR Form (scanned) 2012.pdf			All	Supporting	

	Review Form	2012.pdf					
CM6 - B	MSSP Quality Assurance Program	Quality Assurance.doc			3	Primary	
CM6 - B	MSSP Site Manual Appendix 25 Service Planning and Utilization Summary (SPUS)	Ap_25_SPUS.pdf			All	Supporting	
CM6 - B	MSSP Site Manual Chapter 4	MSSP Chapter_4.docx			Sect. 4.030-4.120 p 2-4	Secondary	
CM6 - B	MSSP Vendor File Assessment Form	Vendor Review for License and Insurance.pdf			All	Supporting	
CM6 - B	Partners in Care Incident Report Form	INCIDENT REPORT.docx	provide new form		All	Supporting	
CM6 - B	PICF CM 6B NARRATIVE	PICF CM 6B_Narrative.docx			ALL	Supporting	
CM6 - B	PICF Survey Results North Office	PICF_surveyresults_north office.docx	staff survey?		all	Supporting	client survey? Utilization review? Need to check
CM6 - B	Vendor Management Protocol - Corrective Action	Vendor Management Protocols - Corrective Action.docx			all	Supporting	
CM6 - C	MSSP CM 6	H:\Product Delivery\Accreditation\Survey Reports\CM\2015\CM01401\add ISS files\MSSP CM 6.docx			all	Primary	
CM6 - C	MSSP South Staff Meeting Survey Follow-Up	MSSP South Staff Meeting Survey Follow-Up.pdf			All	Supporting	need to check
CM6 - D	MSSP CM 8 Patient Rights	MSSP_CM 8_Client Rights.docx			All	Primary	
CM6 - D	MSSP CM 8.1 Incident Report	MSSP CM 8.1.docx			All	Primary	
CM6 - D	MSSP Patient Satisfaction Questionnaire	Client Satisfaction Questionnaire1.doc	provide updated questionnaire		All	Supporting	
CM6 - D	MSSP Site Manual Chapter 3	MSSP Chapter 3.docx			Sect. 3.420, p15	Secondary	
CM6 - D	MSSP Site Manual Chapter 8	MSSP Chapter 8.docx			References Section, p.	Secondary	
CM6 - E	MSSP Kern Site 51 1st Quarterly Report	MSSP Kern_Site_51_1st_QR_FY14-15-Updated Oct17.xlsm	provide updated report		All	Supporting	need updated for each site
CM6 - E	MSSP Kern Site 51 2nd Quarterly Report	QR MSSP Kern_Site_51_2nd_QR_FY14-15 (2).xlsm	provide updated report		All	Supporting	
CM6 - E	MSSP North Site 40 1st Quarterly Report	MSSP North_Site_40_1st_QR_FY14-15-Updated Oct17.xlsm	provide updated report		All	Supporting	
CM6 - E	MSSP North Site 40 2nd Quarterly Report	QR MSSP North_Site_40_2nd_QR_FY14-15 (2).xlsm	provide updated report		All	Supporting	
CM6 - E	MSSP Quarterly Analysis Tool	MSSP 2014-15 Quarterly Report Form.xlsm	provide updated tool if applicable		All	Supporting	Hugo will send
CM6 - E	MSSP Site Manual Appendix 25 Service Planning and Utilization Summary (SPUS)	Ap_25_SPUS.pdf	provide updated spus)		All	Supporting	pull from manual
CM6 - E	MSSP South Site 43 1st Quarterly Report	QR South_Site 43 QR_FY14-15-Quarter 1 (21.xlsm	provide updated report		All	Supporting	

CM6 - E	MSSP South Site 43 2nd Quarterly Report	QR South_Site 43_FY14-15-Quarter 2.xlsm	provide updated report		all	Supporting	
CM6 - F	MSSP Vendor information summary	H:\Product Delivery\Accreditation\Survey Reports\CM\2015\CM01401\addISSfiles\MSSP_VENDOR_INFORMATION_SUMMARY.pdf	provide updated summary		all	Primary	get from Pam Mitchell
CM6 - G	MSSP Quality Assurance Program	Quality Assurance.doc	provide updated program		1	Primary	
CM6 - G	MSSP Quarterly Analysis Tool	MSSP 2014-15 Quarterly Report Form.xlsm	provide updated tool		1	Supporting	Hugo sent
CM7 - A	MSSP CM 7 Staffing, Training, Verification	MSSP CM7.docx	provide updated verification		p. 1	Primary	possibly have to get from Briana
CM7 - A	MSSP Site Manual Chapter 2 Staffing	MSSP Chapter_2.docx	Should not have changed.		2.3 References p6-7	Secondary	
CM7 - A	Partners License Verification Policy	Partners License Verification Policy.docx	Can omit this since the policy is now organization wide.		All	Primary	
CM7 - A	Resource Allocation Table	RESOURCE ALLOCATION TABLE--MSSP.docx	Important: Need to see if it has been updated since the inaugural of the 4th MSSP Site (SB). As of 10/24/2016 this has been		All	Supporting	
CM7 - B	JD Social Work Care Manager 2012 Highlighted	JD Social Work.Care.Manager2012 HIGHLIGHTED.doc	Page numbers are old. Needs to be updated.		All	Supporting	
CM7 - B	MSSP Chapter 3	MSSP Chapter_3.docx	Update to current manual		17 (lines 25-27); 30(lines 27-30); 34 (lines 5-11and 22-24); 56 (lines 16-19)	Secondary	
CM7 - B	MSSP CM 7 Staffing, Training, Verification	MSSP CM7.docx	Needs to be updated		2	Primary	
CM7 - B	MSSP Job Descriptions	MSSP Job Descriptions.pdf	Needs to be updated to new version that Sandy		All	Supporting	
CM7 - B	MSSP Policy- Procedure on CM Processes-Staff-Timelines	MSSP Policy-Procedure on CM Processes-Staff-Timeliness.docx	Needs to be updated.		All	Primary	
CM7 - B	MSSP Site Manual Appendix 14 PHI Authorization	Ap_14 Authorization_for_Use_&_Disclosure_of_PHI.pdf	Pull from new site manual and cross check to make sure this is included in the patients' records		All	Supporting	
CM7 - B	MSSP Site Manual Chapter 3	MSSP Chapter 3.docx	provide updated chapter 3		Sect. 3.030 p3-4	Secondary	
CM7 - C	CDA Disaster Assistance Handbook	Disaster Assistance Handbook.docx	Erlin looked at the Handbook available online by CDA and it has not been updated or revised since 2010		All	Supporting	
CM7 - C	MSSP CM 1 Program Narrative	MSSP CM1 Narrative FINAL.docx	provide updated narrative		p. 1	Primary	
CM7 - C	MSSP CM 7 Staffing, Training, Verification	MSSP CM7.docx	provide updated verification		3-4	Primary	may need to get from Briana
CM7 - C	MSSP Community Resources Guide	Community Resources.docx	Need to look for updated version. As of 10/24/2016, have received South and Kern resources. Still need North and Santa Barbara		All	Supporting	Renee, Hugo, Patricia, Sandra, and Melissa
CM7 - C	MSSP Site Manual Chapter 1	MSSP Chapter_1.docx	provide updated chapter 1		References Section 1.100, p. 1	Secondary	

CM7 - C	MSSP Success Story	MSSP Success Story.docx	Need a new story from North or South Site. As of 10/24/2016, have an updated success story		All	Supporting	Communications
CM7 - C	NCM-SWCM Orientation Checklist	NCM-SWCM_ORIENTATION_Chklst.pdf	Look for updated checklist in the updated manual		All - specific pages referenced in OIF	Supporting	pull from manual
CM7 - C	Partners Policy on Required Trainings	Policy and Procedure_Required Trainings.doc	Programmatic and individual goal settings need to be included		All	Primary	
CM7 - C		Email from last years fire drill	Need to include email of Fire Drill				Tahirah
CM7 - D	Midyear Performance Appraisal Form	Midyear Performance Appraisal Form.pdf	provide updated form		All	Supporting	Tahirah
CM7 - D	MSSP CM 7 Staffing, Training, Verification	MSSP CM7.docx	provide updated verification		4-5	Primary	may need to get from Briana
CM7 - D	Partners Performance Appraisal Form	PerformanceAppraisal-2010 form.doc	provide updated form		All	Supporting	Tahirah
CM7 - E	BRN Guidelines on Sanctions	BRN GUIDELINES RE- SANCTIONS 2014 FROM WEBSITE-2014.pdf	provide updated sanctions		All	Supporting	pull from BRN websites, Erlin check, not updated
CM7 - E	Credentialing File Results	H:\Product Delivery\Accreditation\Survey Reports\CM\2015\CM01401\Copy of cred_file_review_results.xls	Obtain a new one from HR		all	Primary	Briana
CM7 - E	MSSP CM 7 Staffing, Training, Verification	MSSP CM7.docx	provide updated verification		3	Primary	may need to get from Briana
CM7 - E	MSSP Quality Assurance Program	Quality Assurance.doc	Tahirah and Marcia will meet to discuss this		2, 4 & 5	Primary	Tahirah and Marcia
CM7 - E	Partners License Verification Policy	Partners License Verification Policy.docx	Remove; replace with staffing, verification, and credential P&P		All	Primary	
CM7 - E	Partners Performance Appraisal Form	PerformanceAppraisal-2010 form.doc	provide updated form		All	Supporting	Tahirah
CM7 - F	BRN Guidelines on Sanctions	BRN GUIDELINES RE- SANCTIONS 2014 FROM WEBSITE-2014.pdf	provide updated sanctions		All	Supporting	
CM7 - F	Partners License Verification Policy	Partners License Verification Policy.docx	provide updated policy		All	Primary	
CM7 - F	Partners Performance Appraisal Form	PerformanceAppraisal-2010 form.doc	provide updated form		All	Supporting	Tahirah
CM8 - A	Authorization for use & disclosure of PHI	Ap_14 Authorization_for_Use_&_Disclosure_of_PHI.pdf	provide updated phi form if applicable		All	Supporting	
CM8 - A	Notice of Privacy Practices	NEED TO ADD	provide updated practices		All	Supporting	
CM8 - A	CA Advance Directive	CA Advance Directive.pdf	New Law and updated doc; need to check on		All	Supporting	same document
CM8 - A	Comprehensive Service List	Comprehensive Service List.docx	Need to ensure that it has been updated		All	Supporting	
CM8 - A	LTSS Fact Sheet Families	LTSS Fact Sheet Families 8.pdf	A separate LTSS fact sheet is needed for CCI; Put together by Comm. Dept; maybe staff qualifications can be added		All	Supporting	Communication Department
CM8 - A	MSSP Application	MSSP Application Eng.pdf	provide updated application if applicable		All - annotated	Supporting	
CM8 - A	MSSP Client Rights Spanish	Ap_12-SPAN_Client_Rights.pdf	provide updated spanish		All	Supporting	

CM8 - A	MSSP CM 6.1 Policies & Procedures	CM6-1 Policy Development Management Review FINAL.doc	Will review at CM 6 Review Meeting		All	Primary	
CM8 - A	MSSP CM 8 Patient Rights	MSSP_CM 8_Client Rights.docx	Need to look for documents that demonstrate the rapport and treatment of our clients; that they are respected and are informed		All	Primary	
CM8 - A	MSSP CM 8.1 Incident Report	MSSP CM 8.1.docx	provide updated report		All	Primary	
CM8 - A	MSSP Quality Assurance Program	Quality Assurance.doc	provide updated program		All	Primary	
CM8 - A	MSSP Site Manual Appendix 12 Client Rights	Ap_12_Client_Rights.pdf	provide updated rights		All	Primary	
CM8 - A	MSSP Site Manual Appendix 22 Care Plan	Ap_22_Care_Plan.pdf	provide updated plan if applicable		All	Supporting	same document
CM8 - A	MSSP Site Manual Appendix 9 Application for MSSP	Ap_09_Application.pdf	provide updated mssp application if applicable		2	Supporting	
CM8 - A	MSSP Site Manual Chapter 3	MSSP Chapter_3.docx	provide updated chapter 3		References p1; 3.420 p14	Secondary	
CM8 - A	MSSP Site Manual Chapter 5	MSSP Chapter_5.docx	provide updated chapter 5		p. 1; Section	Secondary	
CM8 - A	Partners Caregiver Brochure	Partners Caregiver Broch 2014 7.pdf	provide updated brochure		All	Supporting	
CM8 - A	Partners in Care Incident Report Form	INCIDENT REPORT.docx	Need to upload new QIR Form		All	Secondary	
CM8 - A	Partners LTSS Services Brochure	LTSS Fact Sheet BeenHomes Patients.10.pdf	Check for update		All	Supporting	Communication Department
CM8 - B	8B MSSP Client Rights Cooperation I nformation	8B MSSP Client Rights Cooperation Information.pdf	provide updated nformation		1		
CM8 - B	MSSP CM 1 Narrative	MSSP CM1 Narrative FINAL.docx	provide updated narrative		5	Primary	
CM8 - B	MSSP CM 8 Patient Rights	MSSP_CM 8_Client Rights.docx	provide updated rights		2	Primary	
CM8 - B	MSSP Site Manual Appendix 12 Client Rights	Ap_12_Client_Rights.pdf	provide updated rights		All	Secondary	
CM8 - B	MSSP Site Manual Chapter 3	MSSP Chapter_3.docx	provide updated chapter 3		Sect. 3.640.1 p24	Secondary	
CM8 - B	MSSP Site Manual Chapter 5	MSSP Chapter_5.docx	provide updated chapter 5		Sect. 5.810 p9	Secondary	
CM8 - C	8-C MSSP Site Manual Chapter 3 p2	8-C MSSP Site Manual Chapter 3 p2.docx	Needs update from new site manual		2	Supporting	
CM8 - C	MSSP CM 1 Narrative	MSSP CM1 Narrative FINAL.docx	Before submitting the narratives, Sandy needs to look at the final, as well at those chosen to review the final narratives		p. 5	Supporting	
CM8 - C	MSSP CM 8 Patient Rights	MSSP_CM 8_Client Rights.docx	provide updated rights		3	Primary	
CM8 - C	MSSP CM 8.1 Incident Report	MSSP CM 8.1.docx	provide updated report		All	Primary	
CM8 - C	MSSP Policy- Procedure on CM Processes-Staff-Timelines	MSSP Policy-Procedure on CM Processes-Staff-Timeliness.docx	provide updated timelines		All	Primary	
CM8 - C	MSSP Quality Assurance Program	Quality Assurance.doc	provide updated program		All	Primary	
CM8 - D	MSSP Quality Assurance Program	Quality Assurance.doc	provide updated program		2	Primary	
CM8 - D	MSSP Site Manual Chapter 3	MSSP Chapter_3.docx	provide updated chapter 3		Section 3.640.2 p25	Secondary	
CM8 - D	MSSP Site Manual Chapter 6	MSSP Chapter_6.doc	provide updated chapter 6		6.100 p. 2	Secondary	

CM9 - A	MSSP Site Manual Chapter 5	MSSP Chapter 5.docx	provide updated chapter 5		References p 2	Secondary
CM9 - A	Partners Policy on Business & Ethical Conduct	PICF PP - Business and Ethical Conduct - CM 7 and 8 - 12292014.docx	provide updated conduct		All	Primary
CM9 - A	Partners Policy on Email	PICF PP - Email - CM 9 - 12292014.docx	provide updated email		All	Primary
CM9 - A	Partners Policy on Incident Response & Reporting	PICF PP - Incident Response and Reporting - CM 9 9 - 12302014.docx	provide updated reporting		All	Primary
CM9 - A	Partners Policy on Information Access Management	PICF PP - Information Access Management - CM 9 4 - 12302014.docx	provide updated management		All	Primary
CM9 - A	Partners Policy on Management, Transfer, Storage of PHI	PICF PP - Management Transfer Storage of PHI - CM 9 - 12232014.docx	provide updated phi		All	Primary
CM9 - A	Partners Policy on Mobile Device Acceptable Use	PICF PP - Mobile Device Acceptable Use BYOD Amendment - CM 03 - 12292014.docx	provide updated use		All	Primary
CM9 - A	Partners Policy on Privacy	PICF PP - Privacy - CM 9 - 12292014.docx	provide updated privacy		All	Primary
CM9 - A	Partners policy on Sanctions	PICF PP - Sanctions - CM 9 10 - 12302014.docx	provide updated sanctions		All	Primary
CM9 - A	Partners Policy on Security Awareness	PICF PP - Security Awareness - CM 9 - 12292014.docx	provide updated awareness		All	Primary
CM9 - B	MSSP CM 9 Policies	MSSP CM	provide updated policies		p. 2	Primary
CM9 - B	MSSP Site Manual Chapter 5	MSSP Chapter 5.docx	provide updated chapter 5		5.200 p. 3	Secondary
CM9 - B	Partners Policy on Information Access Management	PICF PP - Information Access	provide updated policy		All	Primary
CM9 - B	Partners Policy on Management, Transfer, Storage of PHI	PICF PP - Management Transfer Storage of PHI - CM 9 - 12232014.docx	provide updated policy		All	Primary
CM9 - B	Partners Policy on Mobile Device Acceptable Use	PICF PP - Mobile Device Acceptable Use BYOD Amendment - CM 03 - 12292014.docx	provide updated policy		All	Primary
CM9 - B	Partners Policy on Privacy	PICF PP - Privacy - CM 9 - 12292014.docx	provide updated policy		All	Primary
CM9 - B	Partners policy on Sanctions	PICF PP - Sanctions - CM 9 10 - 12302014.docx	provide updated policy		All	Primary
CM9 - C	MSSP CM 9 Policies	MSSP CM	provide updated policies		3	Primary
CM9 - C	Partners Policy on Acceptable Use of Info Tech Assets	PICF PP - Acceptable Use of Information Technology Assets - CM 01 - 12292014.docx	provide updated policy		All	Primary

CM9 - C	Partners Policy on Disaster Recovery & Business Continuity	PICF PP - DR BCP - CM 100 - 01012015.docx			All	Primary
CM9 - C	Partners Policy on Email	PICF PP - Email - CM 9 - 12292014.docx	Provide updated policy		All	Primary
CM9 - C	Partners Policy on Incident Response & Reporting	PICF PP - Incident Response and Reporting - CM 9 9 - 12302014.docx	Provide updated policy		2-4	Primary
CM9 - C	Partners Policy on Information Access Management	PICF PP - Information Access Management - CM 9 4 - 12302014.docx	provide updated policy		All	Primary
CM9 - D	MSSP CM 6.1 Policies &	CM6-1 Policy	provide updated policy		p. 1	Primary
CM9 - D	MSSP CM 9 Policies	MSSP CM	provide updated policy		3	Primary
CM9 - D	Partners Policy on Privacy Officer Assignment	PICF PP - Security and Privacy Officer Assignments - CM 9 7 - 12302014.docx	provide update policy		All	Primary
CM9 - E	MSSP CM 9 Policies	MSSP CM	provide updated policies		3	Primary
CM9 - E	MSSP Site Manual Appendix 12 Client Rights	Ap_12_Client_Rights.pdf			All	Secondary
CM9 - E	MSSP Site Manual Chapter 3	MSSP Chapter_3.docx			14	Primary
CM9 - E	Partners Confidentiality Agreement	PICF Confidentiality agreement.doc	provide update agreement if applicable		All	Secondary
CM9 - E	Partners Policy on Required Trainings	Policy and Procedure_Required Trainings.doc	provide updated policy		All	Primary
CM9 - F	MSSP Site Manual Appendix 12 Client Rights	Ap_12_Client_Rights.pdf			All	Supporting
CM9 - F	MSSP Site Manual Appendix 14 PHI Authorization	Ap_14 Authorization_for_Use_&_Disclosure_of_PHI.pdf			All	Supporting
CM9 - F	MSSP Site Manual Chapter 3	MSSP Chapter_3.docx			3.510 p. 15	Secondary
CM9 - F	Partners Policy on Management, Transfer, Storage of PHI	PICF PP - Management Transfer Storage of PHI - CM 9 - 12232014.docx	provide updated policy		All	Primary
CM9 - F	Partners Policy on Mobile Device Acceptable Use	PICF PP - Mobile Device Acceptable Use BYOD Amendment - CM 03 - 12292014.docx	provide updated policy		All	Primary
CM9 - F	Partners Policy on Privacy	PICF PP - Privacy - CM 9 - 12292014.docx	provide updated policy		All	Primary
CM9 - G	MSSP CM 9	H:\Product Delivery\Accreditation\Survey Reports\CM\2015\CM01401\add ISS files\MSSP CM 9.docx			all	Primary

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