

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Quality and Patient Safety

**Managed Long-Term Care
Annual Technical Report**

Reporting Year: 2015

May 2019

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Section One: About This Report

New York State (NYS) is dedicated to providing and maintaining the highest quality of care for enrollees in managed long-term care (MLTC) plans. MLTC enrollees are generally chronically ill, often elderly enrollees and are among the most vulnerable New Yorkers. The New York State Department of Health's (NYSDOH) Office of Quality and Patient Safety (OQPS) employs an ongoing strategy to improve the quality of care provided to plan enrollees, to ensure the accountability of these plans and to maintain the continuity of care to the public.

The MLTC Plan-Technical Report is an aggregate report on the MLTC plans certified to provide Medicaid coverage in NYS. The report is organized into the following domains: Plan Profile, Enrollment, Member Satisfaction, Uniform Assessment System (UAS) Clinical Data, and Performance Improvement Projects (PIPs). When available and appropriate, the plans' data in these domains are compared to statewide benchmarks.

The final section of the report provides an assessment of the MLTC plans' strengths and opportunities for improvement in the areas of service quality, accessibility, and timeliness. For areas in which the plan has opportunities for improvement, recommendations for improving the quality of the MLTC plan services are provided.

There are four (4) MLTC plan types:

- a) Partially Capitated
- b) Program of All-inclusive Care for the Elderly (PACE)
- c) Medicaid Advantage Plus (MAP)
- d) Fully Integrated Duals Advantage (FIDA)

A description of each of the plan types follows:

Partially Capitated - A Medicaid capitation payment is provided to the plan to cover the costs of long term care and selected ancillary services. The member's ambulatory care and inpatient services are paid by Medicare if they are dually eligible for both Medicare and Medicaid, or by Medicaid if they are not Medicare eligible. For the most part, those who are only eligible for Medicaid receive non-MLTC services through Medicaid fee for service, as members in partially capitated MLTC plans are ineligible to join a traditional Medicaid managed care plan. The minimum age requirement is 18 years.

PACE - A PACE plan provides a comprehensive system of health care services for members 55 and older, who are otherwise eligible for nursing home admission. Both Medicaid and Medicare pay for PACE services on a capitated basis. Members are required to use PACE physicians. An interdisciplinary team develops a care plan and provides ongoing care management. The PACE plan is responsible for directly providing or arranging all primary, inpatient hospital and long-term care services required by a PACE member. The PACE is approved by the Centers for Medicare and Medicaid Services (CMS).

Medicaid Advantage Plus (MAP) - MAP plans must be certified by the NYSDOH as MLTC plans and by CMS as a Medicare Advantage plan. As with the PACE model, the plan receives a capitation payment from both Medicaid and Medicare. The Medicaid benefit package includes the long term care services and the Medicare benefit package includes the ambulatory care and inpatient services.

Fully Integrated Duals Advantage (FIDA) - FIDA is a joint Medicare and Medicaid demonstration designed to integrate care for New Yorkers who have both Medicare and Medicaid and who reside in the targeted geographic area (Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk or Westchester counties). Beneficiaries receive both Medicare and Medicaid coverage, including Part D prescription drugs, from a single, integrated FIDA managed care plan. FIDA is jointly administered by CMS and NYSDOH.

An MLTC plan can service more than one of the above products and, where applicable, the report will present data for each product.

In an effort to provide the most consistent presentation of this varied information, the report is prepared based upon data for the most current calendar year available. Where trending is desirable, data for prior calendar years may also be included. This report includes data for reporting year 2015.

Section Two: Plan Profiles

Plan Name	Product Line(s)	Age Requirement	Contact Info	Participating Counties and Programs*
Aetna Better Health	Partially capitated/FIDA	21 and older	www.Aetnabetterhealth.com 55 W 125th St #1300 New York, NY 10027 (855) 456-9126	Kings, Nassau, New York, Suffolk, Queens
AgeWell New York	Partially capitated/FIDA	21 and older	www.agewellnewyork.com 1991 Marcus Ave M201 New Hyde Park, NY 11042 (866) 586-8044	Bronx, Kings, Nassau, New York, Queens, Suffolk, Westchester
AlphaCare	Partially capitated/FIDA	21 and older	www.alphacare.com 335 Adams St #2600 Brooklyn, NY 11201 (888) 770-7811	Bronx, Kings, New York, Queens, Westchester
ArchCare Community Life (partial) Senior Life (PACE)	Partially capitated/PACE	Partial: 21 and older PACE: 55 and older	www.archcare.org Partial: 33 Irving Place, 11 th Fl New York, NY 10003 PACE: 1432 Fifth Ave New York, NY 10035 900 Intervale Ave Bronx, NY 10459 88 Old Town Road Staten Island, NY 10304 Partial: (855) 467-9351 PACE: (866) 263-9083	Bronx (partial/PACE), Kings (partial), New York (partial/PACE), Queens (partial), Richmond (partial/PACE), Putnam (partial), Westchester (partial)
CareConnect	Partially capitated/FIDA	18 and older	www.careconnect.com 2200 Northern Blvd East Hills, NY 11548 (855) 421-3066	Kings, Queens, New York, Richmond, Nassau, Suffolk
Catholic Health LIFE	PACE	55 and older	www.chsbuffalo.org 55 Melroy Ave Lakawanna, NY14218 (716) 819-5102	Erie
CenterLight	Partially capitated/PACE/FIDA	Partial: 18 and older PACE: 55 and older	www.centerlighthealthcare.org 1250 Waters Pl, Tower 1, Suite 602, Bronx, NY 10461 (877) 226-8500	NYC (all boroughs) (partial/PACE), Nassau (partial/PACE), Rockland (partial), Suffolk (partial/PACE), Westchester (partial/PACE)
Centers Plan for Healthy	Partially capitated/FIDA	21 and older	www.centersplan.com	NYC (all boroughs), Erie, Niagara, Rockland

Plan Name	Product Line(s)	Age Requirement	Contact Info	Participating Counties and Programs*
Living			75 Vanderbilt Ave, 7 th Floor Staten Island, NY 10304 (855) 270-1600	
Complete Senior Care	PACE	55 and older	www.completeseniorcare.org 1302 Main St Niagara Falls, NY 14301 (888) 303-4333	Niagara
Eddy Senior Care	PACE	55 and older	www.nehealth.com 504 State St Schenectady, NY 12305 (518) 382-3290	Albany and Schenectady
ElderOne	PACE	55 and older	www.rochestergeneral.org 2066 Hudson Ave Rochester, NY 14617 (585) 922-2831	Monroe
Elderplan/Homefirst	MAP/partially capitated/FIDA	18 and older	www.elderplan.org 6323 Seventh Ave Brooklyn, NY 11220 (800) 353-3765	Dutchess (partial/MAP), Monroe (MAP), Nassau (partial/MAP/FIDA), NYC (all boroughs) (partial/MAP/FIDA), Orange (partial), Putnam (partial), Rockland (partial), Suffolk (partial), Sullivan (partial), Ulster (partial), Westchester (partial/MAP)
ElderServe Health	Partially capitated/FIDA	18 and older	www.riverspringathome.org 94 W 225th St Bronx, NY 10463 (800) 370-3600	Nassau, NYC (all boroughs), Suffolk, Westchester
Empire Blue Cross Blue Shield HealthPlus	Partially capitated/MAP	18 and older	www.empireblue.com 9 Pine St 14 th Fl New York, NY 10005 (800) 950-7679	NYC (all boroughs)
EverCare Choice	Partially capitated	18 and older	www.evercare.org 31 Cerone Pl Newburgh, NY 12550 (877) 255-3678	Dutchess, Orange, Rockland
Extended MLTC	Partially capitated	21 and older	www.extendedmltc.org 360 West 31 st St, Suite 304 New York, NY 10001 (855) 299-6492	Nassau, NYC (all boroughs), Suffolk
Fallon Health Weinberg	Partially capitated	55 and older	www.fallonweinberg.org 461 John James Audubon Pkwy Amherst, NY 14228 (855) 665-1113	Erie and Niagara
Fidelis	MAP/partially capitated/ FIDA	18 and older	www.fideliscare.org 95-25 Queens Blvd	Albany (partial/MAP), Bronx (partial/MAP), Kings (partial/MAP), New York (partial/MAP), Queens (partial/MAP), Rensselaer (partial/MAP),

Plan Name	Product Line(s)	Age Requirement	Contact Info	Participating Counties and Programs*
			Rego Park, NY 11374 Partial: (800) 688-7422 MAP: (877) 533-2404	Richmond (partial/MAP), Schenectady (partial/MAP)
GuildNet	MAP/partially capitated/ FIDA	18 and older	www.lighthouseguild.org 15 W 65th St New York, NY 10023 Partial: (800) 932-4703 MAP: (800) 815-0000	Nassau (partial/MAP), NYC (all boroughs) (partial/MAP*), Suffolk (partial/MAP), Westchester (partial) *MAP product not offered in Staten Island
Hamaspik Choice	Partially capitated	18 and older	www.hamaspikchoice.org 58 Rt. 59, Suite 1 Monsey, New York 10952 (855) 552-4642	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster
iCircle Care	Partially capitated	18 and older	www.icirclecny.org 860 Hard Rd Webster, NY 14580 (844) 424-7253	Broome, Cayuga, Chemung, Chenango, Cortland, Genesee, Livingston, Madison, Monroe, Onondaga, Ontario, Orleans, Oswego, Otsego, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming, Yates
Independence Care System	Partially capitated/ FIDA	18 and older	www.icsny.org 257 Park Ave South, 2nd Floor New York, NY 10010 (877) 427-2525	Bronx, Kings, New York, Queens
Integra	Partially capitated	18 and older	Integrplan.org 1981 Marcus Ave, Suite 100 New Hyde Park, NY 11042 (855) 800-4683	Nassau, NYC (all boroughs), Suffolk, Westchester
Kalos	Partially capitated	18 and older	www.kaloshealth.org 2424 Niagara Falls Blvd Niagara Falls, NY 14304 (800) 894-2464	Chautauqua, Erie, Genesee, Niagara, Orleans
MetroPlus	Partially capitated/FIDA	21 and older	www.metroplus.org 160 Water St #3 New York, NY 10038 (855) 355-6582	Bronx, Kings, New York, Queens
Montefiore HMO	Partially capitated	21 and older	www.montefiore.org 200 Corporate Blvd South Yonkers, New York 10701 (855) 556-6683	Bronx, Westchester
PACE CNY	PACE	55 and older	www.pacecny.org 100 Malta Ln North Syracuse, NY 13212 (888) 728-7223	Onondaga
Prime Health Choice	Partially capitated	21 and older	www.primehomehealth.com	Albany, Dutchess, Orange, Putnam, Rockland, Warren, Washington

Plan Name	Product Line(s)	Age Requirement	Contact Info	Participating Counties and Programs*
			3125 Emmons Ave Brooklyn, NY 11235 (855) 777-4630	
Senior Health Partners/Healthfirst	Partially capitated/MAP/FIDA	Partial: 21 and older MAP: 18 and older	www.shpny.org 100 Church St, 18 th Fl New York, NY 10007 Partial: (866) 585-9280 MAP: (888) 260-1010 FIDA: (855) 675-7630	NYC (All boroughs), Nassau, Westchester* *MAP product not offered in Westchester
Senior Network Health	Partially capitated	18 and older	www.faxtonstlukes.com/senior-network-health 1650 Champlin Ave Utica, NY 13502 (888) 355-4764 (315) 624-4545	Herkimer and Oneida
Senior Whole Health	MAP/partially capitated/FIDA	Partial: 21 and older MAP/FIDA: 65 and older	www.seniorwholehealth.com 111 Broadway, Suite 1505 New York, NY 10006 (877) 353-0185	Bronx, Kings, New York, Queens
Total Senior Care	PACE	55 and older	www.totalseniorcare.org 519 North Union St Olean, NY 14760 (866) 939-8613	Allegany, Cattaraugus, Chautauqua
UnitedHealthcare	Partially Capitated	18 and older	www.uhccommunityplan.com 77 Water St., 14th Fl New York, NY 10005 (877) 512-9354	NYC (All boroughs), Albany, Broome, Erie, Monroe, Oneida, Onondaga, Orange, Rockland
VillageCareMAX	Partially capitated/FIDA	18 and older	www.villagecare.org 112 Charles St New York, NY 10014 (800) 469-6292	Bronx, Kings, New York, Queens
VNA Homecare Options	Partially capitated	18 and older	www.VNAhomecareoptions.org 1050 W. Genesee St Syracuse, NY 13204 (855) 877-8868	Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, St. Lawrence, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Tioga, Tompkins, Warren, Washington, Wayne, Wyoming, Yates
VNSNY Choice	MAP/partially capitated/FIDA	18 and older	www.vnsnychoice.org 1250 Broadway, 11th Floor	NYC (all boroughs)*, Albany, Columbia, Delaware, Dutchess, Erie, Fulton, Greene, Herkimer, Madison, Monroe,

Plan Name	Product Line(s)	Age Requirement	Contact Info	Participating Counties and Programs*
			New York, NY 10001 Partial: (888) 867-6555 MAP: (866) 597-6674	Montgomery, Nassau*, Oneida, Onondaga, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk*, Sullivan, Ulster, Warren, Washington, Westchester* *MAP product offered in these counties only
WellCare	Partially capitated/FIDA	18 and older	www.wellcare.com 1 New York Plaza, 15th Floor New York, NY 10004 Partial: (866) 661-1232 FIDA: (855) 595-2063	NYC (All boroughs), Albany, Erie, Orange, Nassau, Rockland, Suffolk, Ulster, Westchester

* Represents information as of March 2016. Please contact the plan directly for the most current list of participating counties and programs.

Section Three: Enrollment

Figure 1A depicts membership for each MLTC plan, stratified by product line, for calendar years 2013 to 2015. The data reported are from the NYSDOH Medicaid Managed Care Monthly Enrollment Reports (from December of each of these years). **Figure 1B** illustrates enrollment trends for calendar years 2013 to 2015.

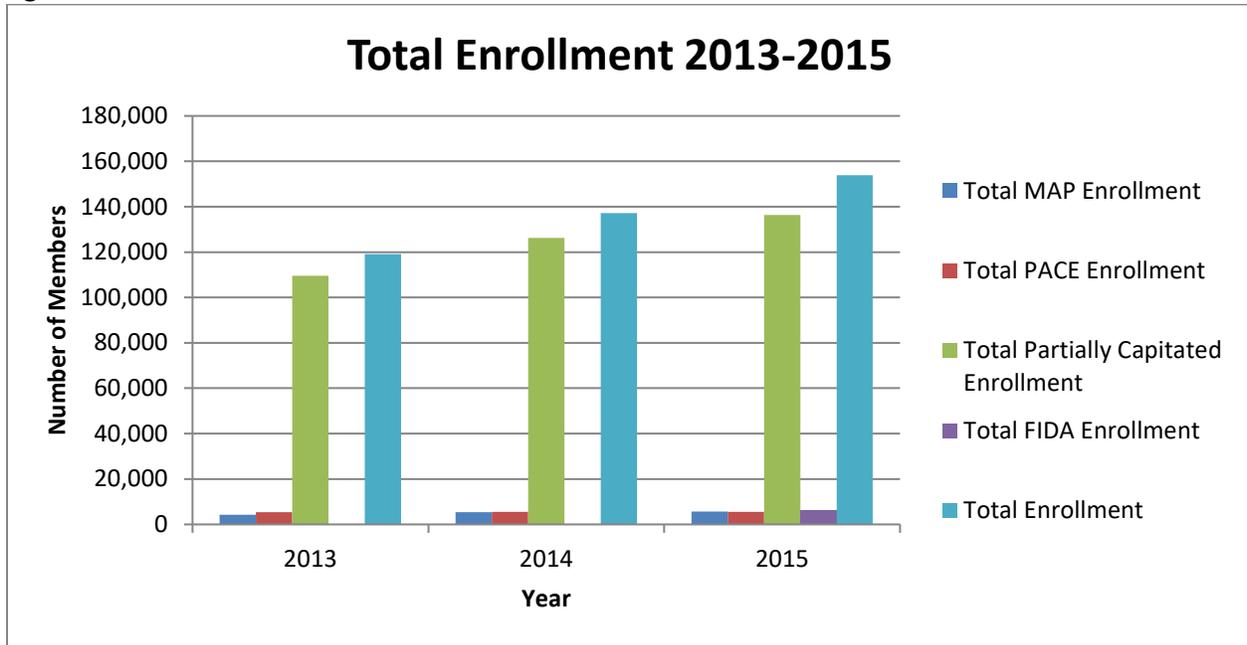
Figure 1A: 2013-2015 MLTC Plan Membership

PACE	2013	2014	2015
ArchCare Senior Life	305	366	452
CenterLight PACE	3,669	3,539	3,279
Catholic Health Life	159	187	201
Complete Senior Care	85	115	123
Eddy Senior Care	143	159	174
ElderOne	470	646	668
PACE CNY	443	470	489
Total Senior Care	91	102	105
<i>Total PACE Enrollment</i>	<i>5,365</i>	<i>5,584</i>	<i>5,491</i>
Partially Capitated	2013	2014	2015
Aetna Better Health of New York	2,119	2,950	3,363
AgeWell New York	2,287	3,978	5,666
AlphaCare	248	1,433	2,176
ArchCare Community Life	1,731	1,939	1,973
CareConnect	301	1,443	2,585
CenterLight	10,024	7,531	5,652
Centers Plan for Healthy Living	1,081	2,081	4,198
Elderplan	11,114	10,822	10,599
ElderServe Health (RiverSpring)	10,238	10,414	10,643
Empire Blue Cross Blue Shield HealthPlus MLTC	2,895	2,897	2,790
EverCare Choice	438	778	860
Extended MLTC	172	344	874
Fallon Health Weinberg	119	147	225
Fidelis Part Cap	7,699	9,769	11,243
GuildNet	14,397	14,513	14,781
Hamaspik Choice	59	612	1,339
iCircle	N/A	N/A	883
Independence Care System	5,046	5,328	5,729
Integra	670	2,191	2,950
Kalos	N/A	213	524
MetroPlus	445	810	939
Montefiore	25	500	691
Prime Health Choice	N/A	15	102
Senior Health Partners	10,867	14,220	12,759
Senior Network Health	450	493	493
Senior Whole Health	605	1,764	3,651
UnitedHealthcare	553	1,139	1,633

Partially Capitated (continued)	2013	2014	2015
VillageCareMAX	2,461	3,517	4,974
VNA Homecare Options	178	543	1,410
VNSNY Choice	17,772	16,924	13,555
WellCare	5,524	6,950	7,134
<i>Total Partially Capitated Enrollment</i>	<i>109,518</i>	<i>126,258</i>	<i>136,394</i>
MAP	2013	2014	2015
Elderplan	851	815	878
Empire Blue Cross Blue Shield HealthPlus MAP	7	7	2
GuildNet	567	726	646
Healthfirst	2,330	3,368	3,784
Fidelis	199	181	150
VNSNY Choice	255	212	87
Senior Whole Health	21	53	112
<i>Total MAP Enrollment</i>	<i>4,230</i>	<i>5,362</i>	<i>5,659</i>
FIDA	2013	2014	2015
Aetna Better Health FIDA	N/A	N/A	62
AgeWell New York FIDA	N/A	N/A	52
AlphaCare Signature FIDA	N/A	N/A	43
CareConnect FIDA LiveWell	N/A	N/A	32
CenterLight	N/A	N/A	215
FIDA Complete Care	N/A	N/A	36
ElderPlan FIDA Total Care	N/A	N/A	307
ElderServe (RiverSpring)	N/A	N/A	13
Fidelis Care FIDA	N/A	N/A	375
GuildNet Gold Plus FIDA	N/A	N/A	922
Healthfirst AbsoluteCare FIDA	N/A	N/A	1251
ICS Community Care Plus FIDA	N/A	N/A	194
MetroPlus FIDA	N/A	N/A	184
VillageCareMax	N/A	N/A	31
VNSNY Choice FIDA Complete	N/A	N/A	2297
WellCare Advocate Complete FIDA	N/A	N/A	207
Senior Whole Health	N/A	N/A	65
<i>Total FIDA Enrollment</i>	<i>N/A</i>	<i>N/A</i>	<i>6,286</i>
Total Enrollment	119,113	137,204	153,830

N/A: Not Applicable (plan was not in operation during this time).

Figure 1B: Enrollment Trends 2013-2015



Section Four: Member Satisfaction

No new survey data were available for 2015. Data from the most recent survey (2014-2015) were presented in the 2013/2014 Plan Technical Reports.

Section Five: Community Health Assessment (CHA)

Effective October 2013, the Semi Annual Assessment of Members (SAAM) tool was replaced by the Uniform Assessment System for NY (UAS-NY) Community Health Assessment (CHA). The UAS-NY is an electronic system based on a uniform data set, which standardizes and automates needs assessments for home and community based programs in New York.¹ Data are immediately available to users during and upon completion of the assessment. The CHA is used by the MLTC plans to conduct clinical assessments at enrollment and at six month intervals thereafter.

This report contains the following items from the Assessment:

Activities of Daily Living (ADL)

Percent of members who could perform the following tasks independently, with setup help/device, or with supervision:

- Dressing Upper Body
- Dressing Lower Body
- Bathing
- Toileting
- Ambulation
- Feeding/Eating

Continence (urinary and bowel)

Percent of members who are continent, have control with catheter/ostomy, or who were infrequently incontinent.

Mood and Behavior

- Cognitive Functioning: Percent of members able to consistently, reasonably, and safely make daily decisions.
- No Anxiety: Percent of members who reported no anxious or restless feelings.
- No Depression: Percent of members who reported no sad, depressed or hopeless feelings.

Health Conditions

- No Pain: Percent of members experiencing no pain
- No Falls Resulting in Medical Intervention

Prevention

- Dental Exam in the last year
- Eye Exam in the last year
- Hearing Exam in the last two years
- Influenza Vaccine in the last year

¹ NYS Department of Health, 2016 Managed Long Term Care Report <http://health.ny.gov>

UAS-NY Reporting Period July 2015 to December 2015

Summary of Findings

Partially Capitated

Compared to members statewide, members in partially capitated plans had similar rates of members who could perform the six activities of daily living (ADL), all physical health indicators, cognitive skills, and all preventive care indicators. Compared to the previous reporting period (January-June 2015), ADL and behavioral health rates decreased slightly, physical health indicators remained consistent, and preventive screening indicators increased slightly.

PACE

Consistent with the previous reporting period, there was a higher percentage of PACE members who reported the ability to perform the six activities of daily living, compared to the rest of the state. Conversely, when compared to the rest of the state, a lower percentage of PACE members reported being urinary (26.7% vs. 35.6%) and bowel continent (75.1% vs. 81.8%), and in addition, a lower percentage of PACE members reported having intact cognitive functioning (21% vs. 28%) and no feelings of anxiety (74.9% vs. 80.3%). In contrast, a higher percentage of PACE members experienced no pain (33.6% vs. 19.7%) and a slightly lower percentage of PACE members experienced no falls requiring medical intervention (83.8% vs. 85.7%). PACE members fared better than the rest of the state on all preventive care indicators.

MAP

Four out of the six activities of daily living indicators were lower among MAP plans compared to the rest of the state. Two of these indicators were slightly higher than the statewide averages: ambulation (47.5% vs. 44.6%) and bathing (12.6% vs. 11.5%). When compared with members statewide, a higher percentage of members in MAP plans were urinary (37.6% vs. 35.6%) and bowel continent (85.9% vs. 81.8%). While a similar percentage of MAP members reported no falls requiring medical intervention (85.8% vs. 85.7%), a lower percentage of MAP members experienced no pain (15.0% vs. 19.7%) and had intact cognitive functioning (23.4% vs. 28.0%). Rates for preventive screenings were higher than statewide, with the exception of dental exams, which a similar percentage of members reported receiving within the past year.

FIDA

All activities of daily living indicators for FIDA plans were consistently lower than the statewide averages, and moreover have decreased from the initial reporting period (January-June). Compared to members statewide, a lower percentage of FIDA members reported being urinary continent (31.8% vs. 35.6%) and bowel continent (75.6% vs. 81.8%). Conversely, a higher percentage of FIDA members reported no pain (22.4% vs. 19.7%) and no falls requiring medical intervention (87.6% vs. 85.7%). Similarly, a higher percentage of FIDA members reported having no depression and no anxiety. Although a slight improvement from the previous reporting period, all preventive screenings indicators were lower for FIDA members compared with members statewide, with the exception of the influenza vaccine, in which 78.6% of FIDA members reported having versus 76.7% of members statewide.

Figure 4 is an overview of the averages for the CHA indicators for each MLTC product line, as well as the weighted averages for each indicator statewide for the Jul 2015 through December 2015 reporting period. Of note, comparisons are made to the January-June 2015 reporting period in some of the individual indicator sections for each plan type that follow Figure 4, but the data are not shown.

Figure 4. UAS-NY July 2015 to December 2015: Summary

CHA Indicator	Statewide mean (N= 151,183)	Partially Cap. Mean (N= 130,385)	PACE mean (N= 5,500)	MAP mean (N= 5,121)	FIDA mean (N= 8,117)
Activities of Daily Living (ADL)					
<i>Ambulation</i>	44.6	44.6	56.2	47.5	33.5
<i>Bathing</i>	11.5	11.4	19.9	12.6	6.9
<i>Upper Body Dressing</i>	26.0	26.2	37.9	24.8	16.3
<i>Lower Body Dressing</i>	12.2	12.1	26.5	9.8	6.3
<i>Toileting</i>	45.6	46.2	59.3	33.7	34.4
<i>Feeding</i>	78.8	78.4	87.6	77.3	75.4
Physical Health Indicators					
<i>Urinary Continence</i>	35.6	36.2	26.7	37.6	31.8
<i>Bowel Continence</i>	81.8	82.4	75.1	85.9	75.6
<i>No Pain</i>	19.7	19.1	33.6	15.0	22.4
<i>No Falls Requiring Medical Intervention</i>	85.7	85.7	83.8	85.8	87.6
Behavioral Health Indicators					
<i>Cognitive Functioning</i>	28.0	29.0	21.0	23.4	23.0
<i>No Anxiety</i>	80.3	80.1	74.9	82.4	86.7
<i>No Depression</i>	68.2	67.8	61.8	71.4	75.6
Preventive Care Indicators					
<i>Dental Exam</i>	50.7	50.8	63.0	50.4	42.0
<i>Eye Exam</i>	73.6	73.4	79.0	77.4	72.0
<i>Hearing Exam</i>	34.8	34.8	40.1	35.5	31.3
<i>Influenza Vaccine</i>	76.7	76.1	85.6	78.7	78.6

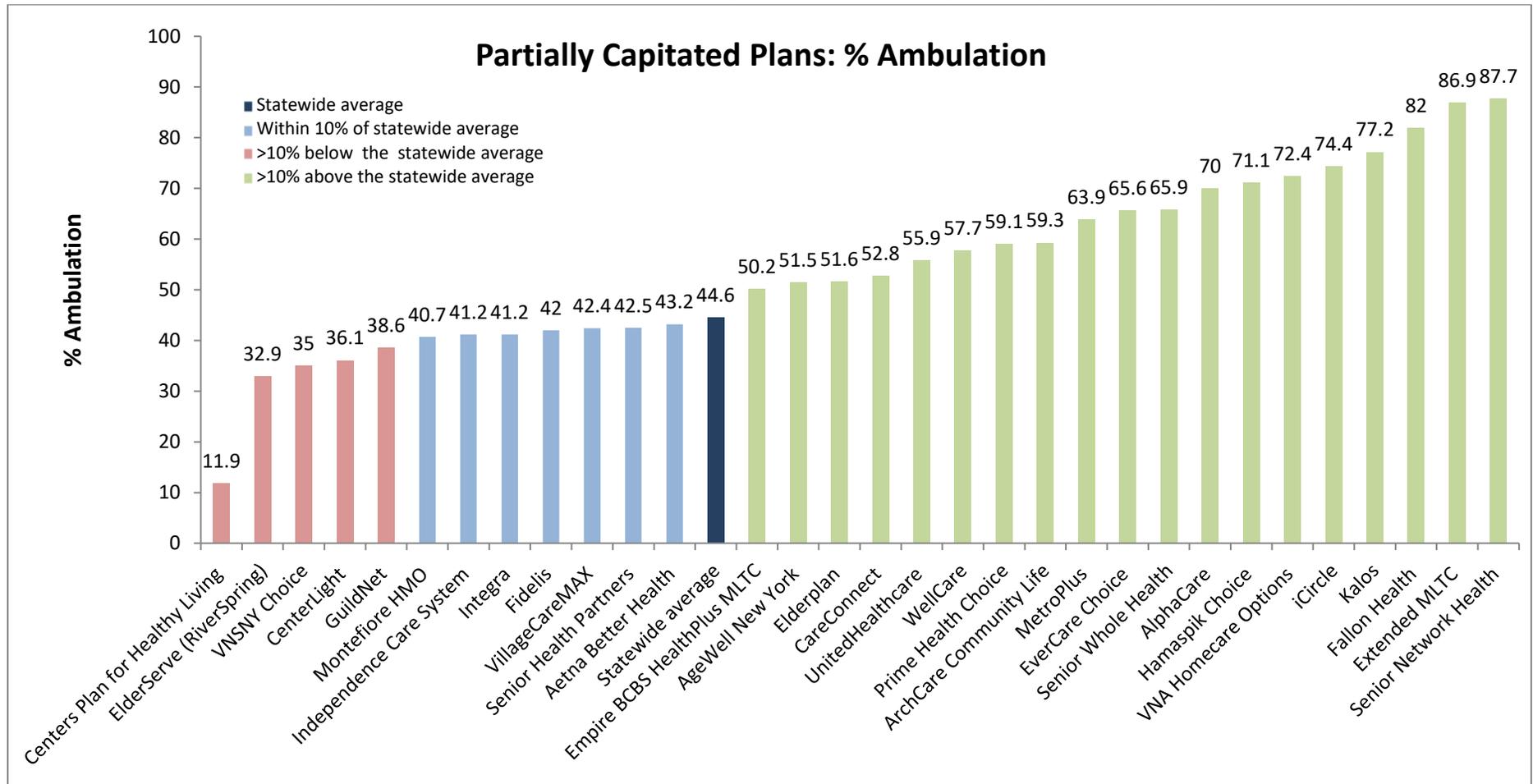
Activities of Daily Living (ADL) Indicators

Ambulation

Partially Capitated

Compared to the previous reporting period, a lower percentage of members statewide indicated that they could perform **ambulation** (48.3% vs. 44.6%) on the July-December assessment. As seen in **Figure 5A**, among the partially capitated plans, there were seven plans that had rates within 10 percent of the statewide average and three of those plans had rates within five percent of the statewide average. There were nineteen partially capitated plans that had rates for ambulation that were greater than the statewide average by more than 10 percent. Conversely, five plans had rates that were greater than 10 percent below the statewide average for this indicator.

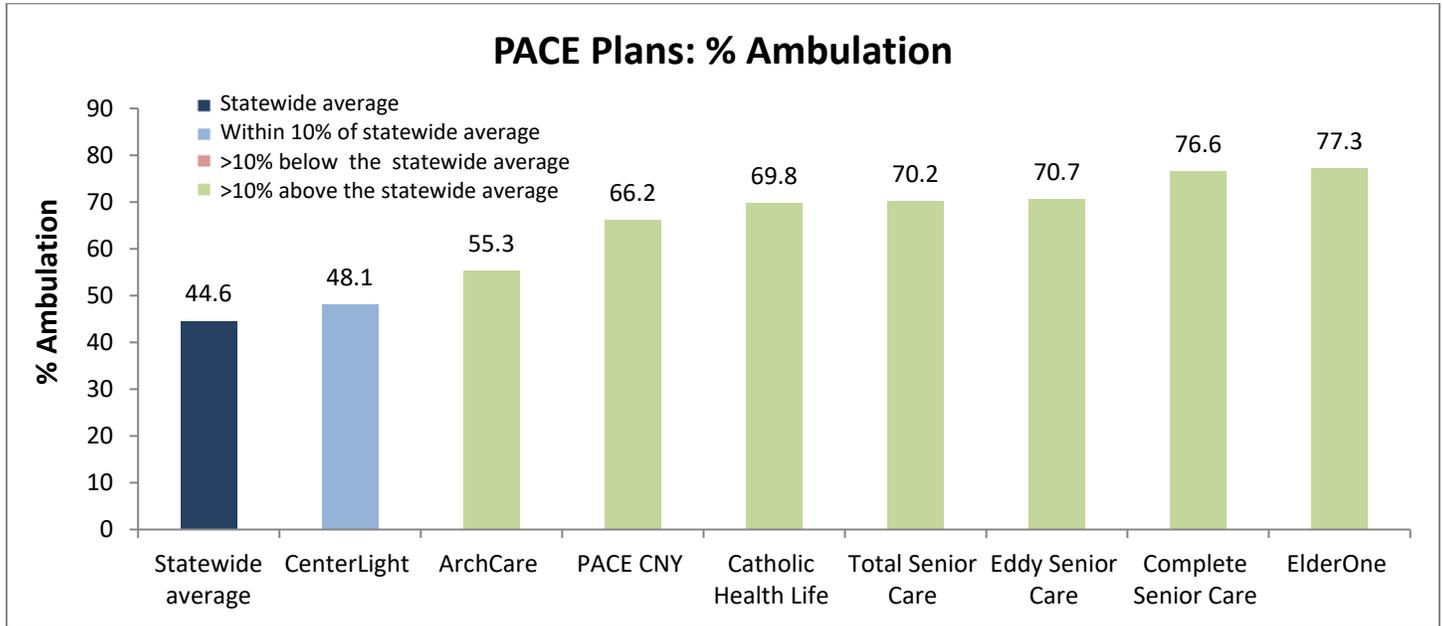
Figure 5A. Percentage of Partially Capitated members who indicated they could ambulate independently, with set up help, or under supervision.



PACE

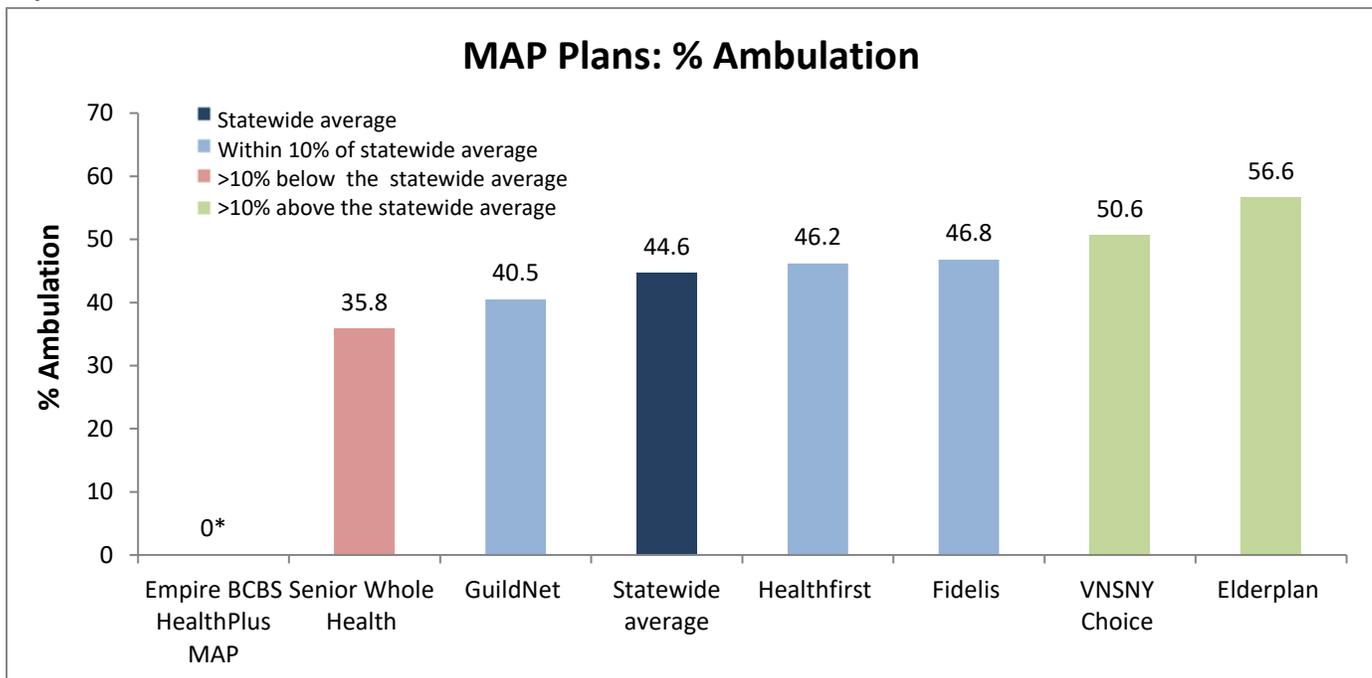
Compared with the January 2015-June 2015 reporting period, the statewide average for ambulation decreased 3.7 percentage points to 44.6% in the July 2015-December 2015 reporting period. As indicated in **Figure 5B**, of the eight PACE plans, one plan's rate for this indicator was within 10 percent of the statewide average. The remaining seven PACE plans had rates that exceeded the statewide average by more than 10 percent.

Figure 5B. Percentage of PACE members who indicated they could ambulate independently, with set up help, or under supervision.



MAP
 The statewide average for **ambulation** decreased 3.7 percentage points to 44.6% in the final reporting period. **Figure 5C** shows that there were three MAP plans that had rates for this indicator that were within 10 percent of the statewide average; two of those plans had rates within five percent of the statewide average. Two plans had rates that were below the statewide average by more than 10 percent. Additionally, two plans had rates that exceeded the statewide average by more than 10 percent.

Figure 5C. Percentage of MAP members who indicated they could ambulate independently, with set up help, or under supervision.

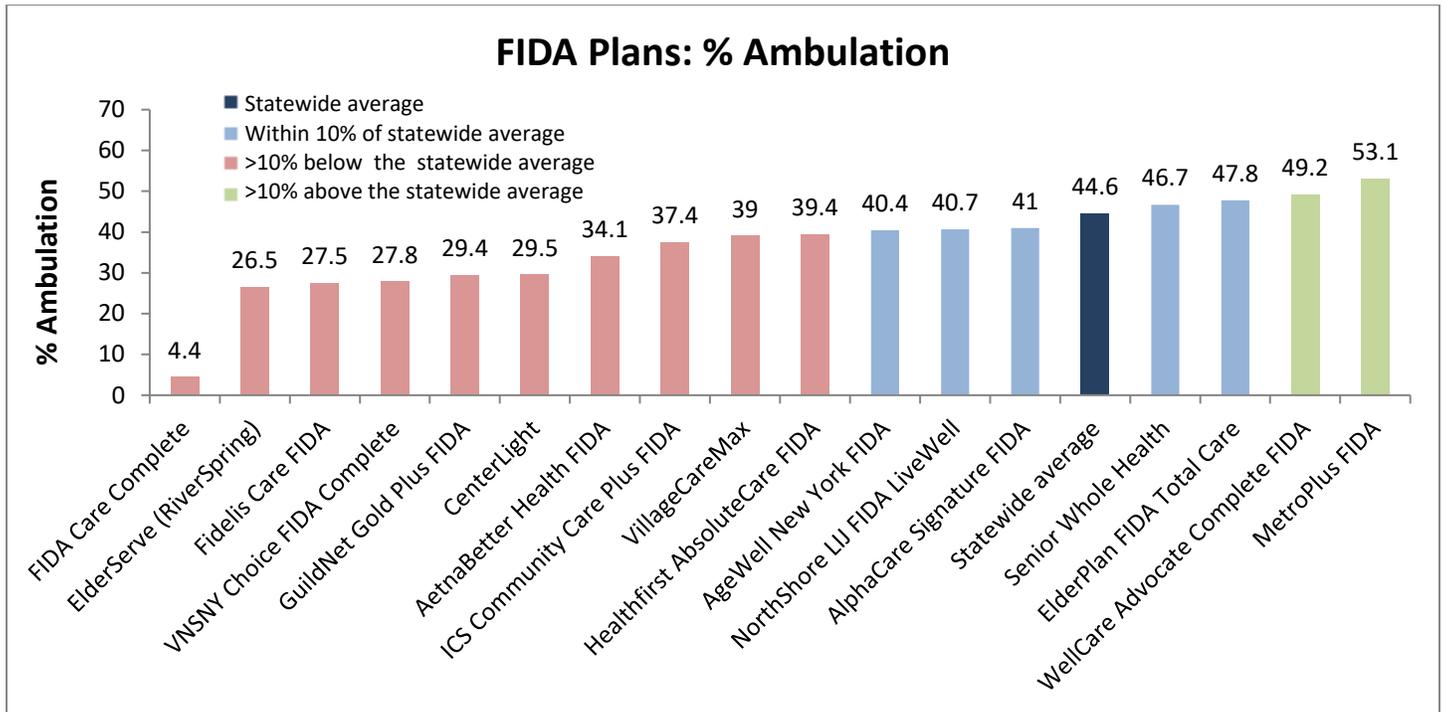


*Rate reflects data from one assessment completed.

FIDA

The statewide average for **ambulation** decreased 3.7 percentage points to 44.6% in the final reporting period. In **Figure 5D**, there were five FIDA plans that had rates that were within 10 percent of the statewide average and one of those plans had a rate that was within five percent of the statewide average. While ten plans had rates that were below the statewide average by more than 10 percent, two plans had rates that exceeded the statewide average by more than 10 percent.

Figure 5D. Percentage of FIDA members who indicated they could ambulate independently, with set up help, or under supervision.

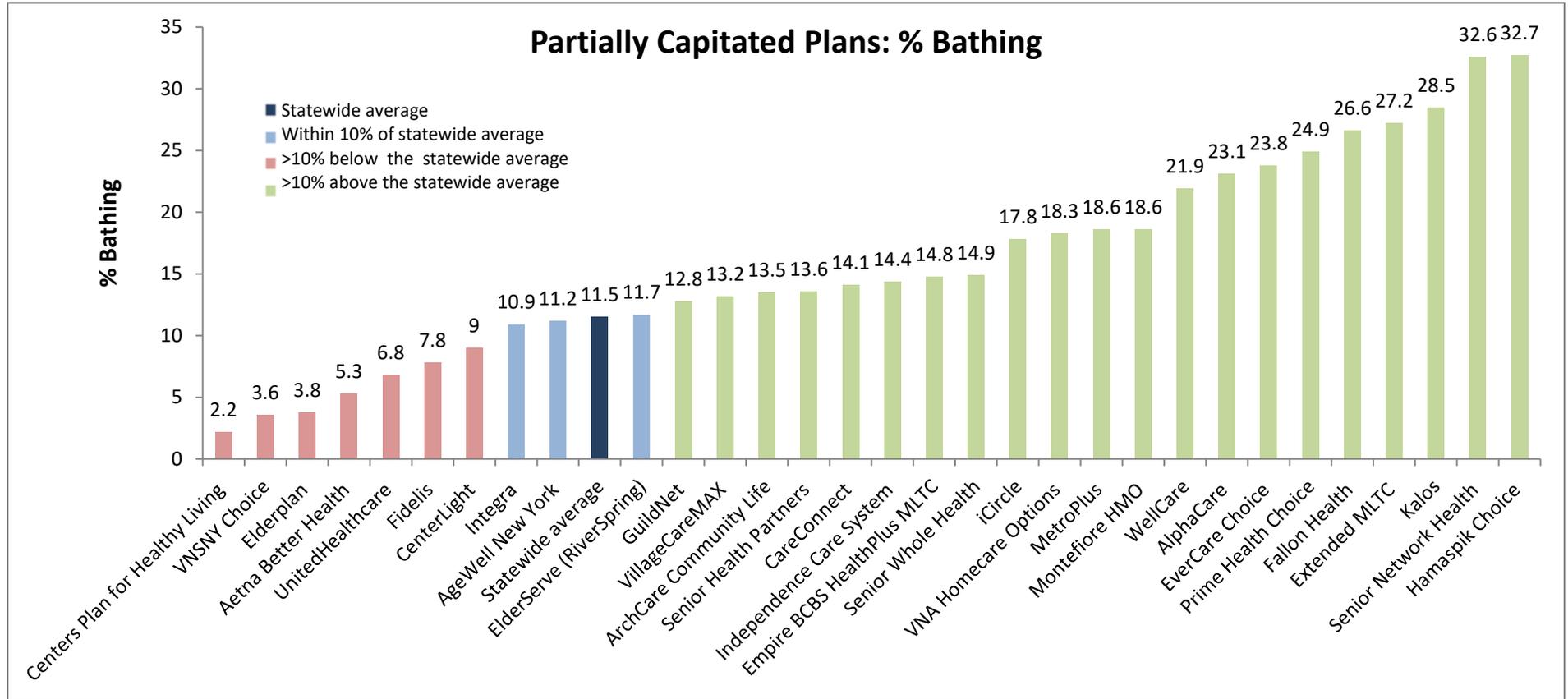


Bathing

Partially Capitated

For **bathing**, the statewide average decreased slightly from the first reporting period to the second reporting period (13.1% vs. 11.5%). As indicated in **Figure 6A** below, Twenty-one partially capitated plans had rates for this indicator that were greater than 10 percent above the statewide average and seven plans that had rates that were greater than 10 percent below the statewide average. Three plans had rates for bathing that fell within 10 percent of the statewide average, two of which had rates that fell within five percent of the statewide average.

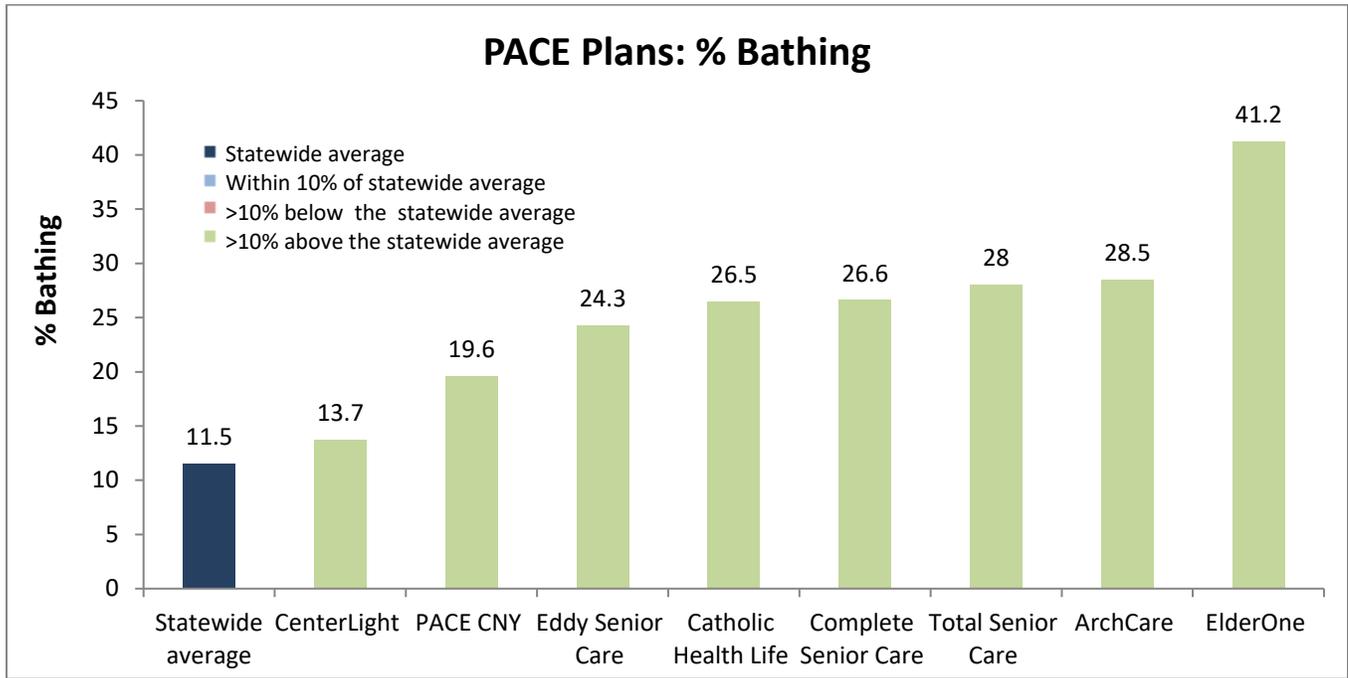
Figure 6A. Percentage of Partially Capitated members who took a full-body bath/shower independently, with setup help, or under supervision.



PACE

The statewide average for **bathing** decreased by 1.6 percentage points to 11.5% in July-December 2015. As indicated by **Figure 6B**, all PACE plans had rates for this indicator that were greater than 10 percent above the statewide average.

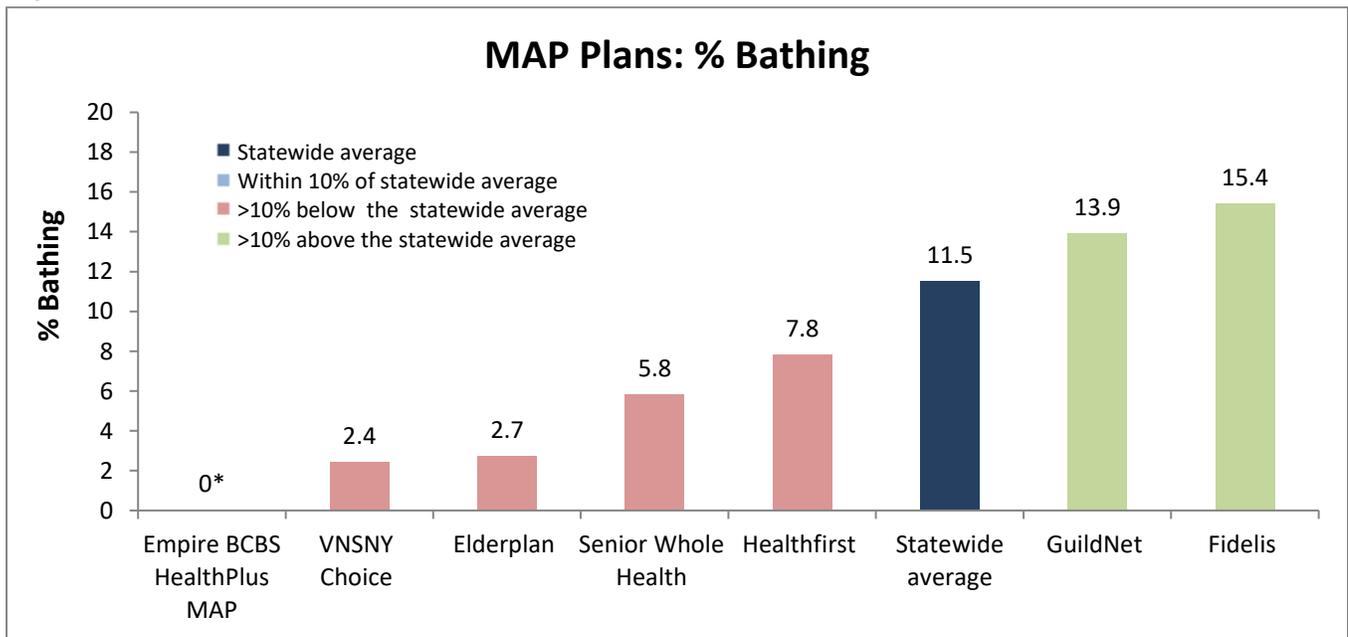
Figure 6B. Percentage of PACE members who took a full-body bath/shower independently, with setup help, or under supervision.



MAP

For **bathing**, the statewide average decreased by 1.6 percentage points to 11.5%. As seen in **Figure 6C**, of the seven MAP plans, two plans had rates for bathing that were greater than 10 percent above the statewide average. The five remaining plans had rates that were more than 10 percent below the statewide average.

Figure 6C. Percentage of MAP members who took a full-body bath/shower independently, with setup help, or under supervision.

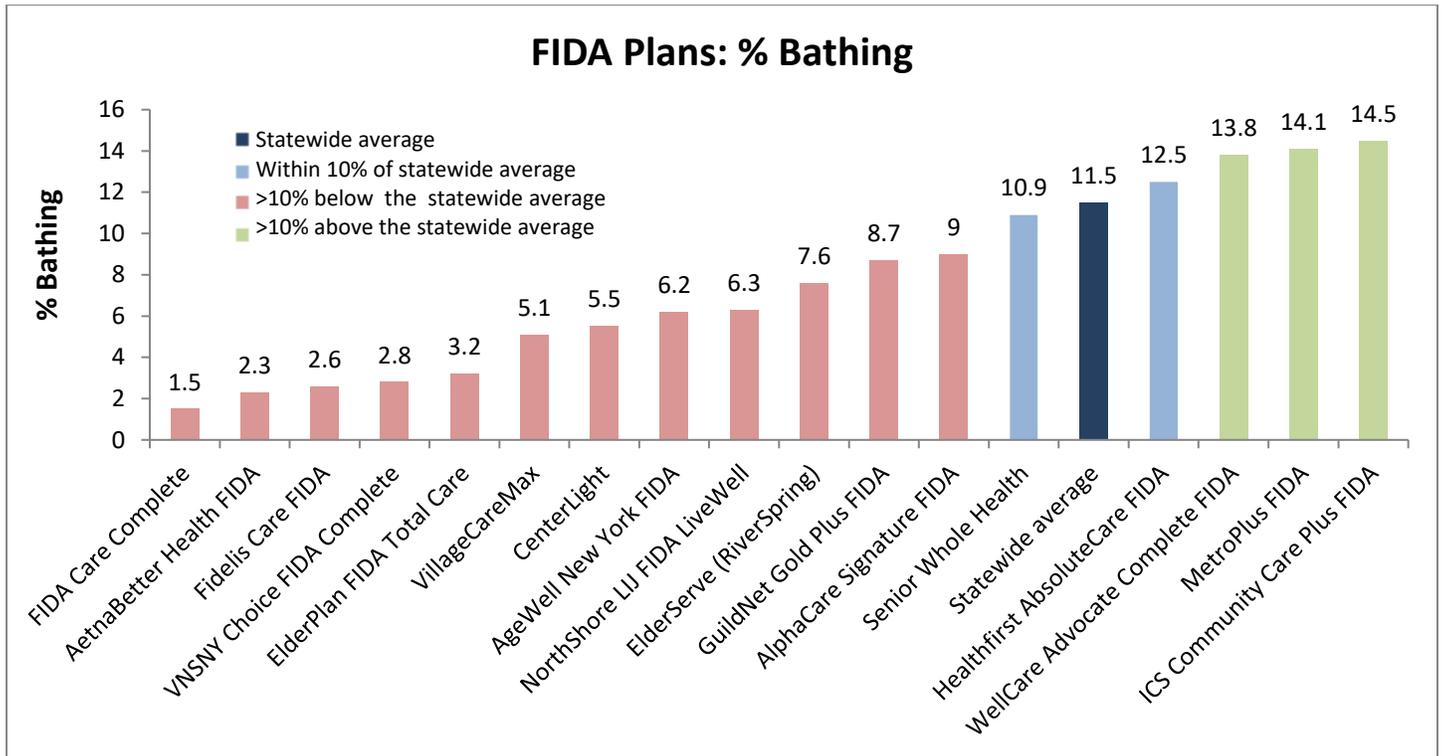


*Rate reflects data from one assessment completed.

FIDA

The statewide average for **bathing** decreased by 1.6 percentage points from 13.1% in the initial reporting period to 11.5% in the final reporting period. **Figure 6D** below shows that there were two plans whose rates were within 10 percent of the statewide average, one of which was within five percent of the statewide average. There were twelve plans that had rates that were greater than 10 percent below the statewide average, and there were three plans that had rates that were greater than 10 percent above the statewide average.

Figure 6D. Percentage of FIDA members who took a full-body bath/shower independently, with setup help, or under supervision.

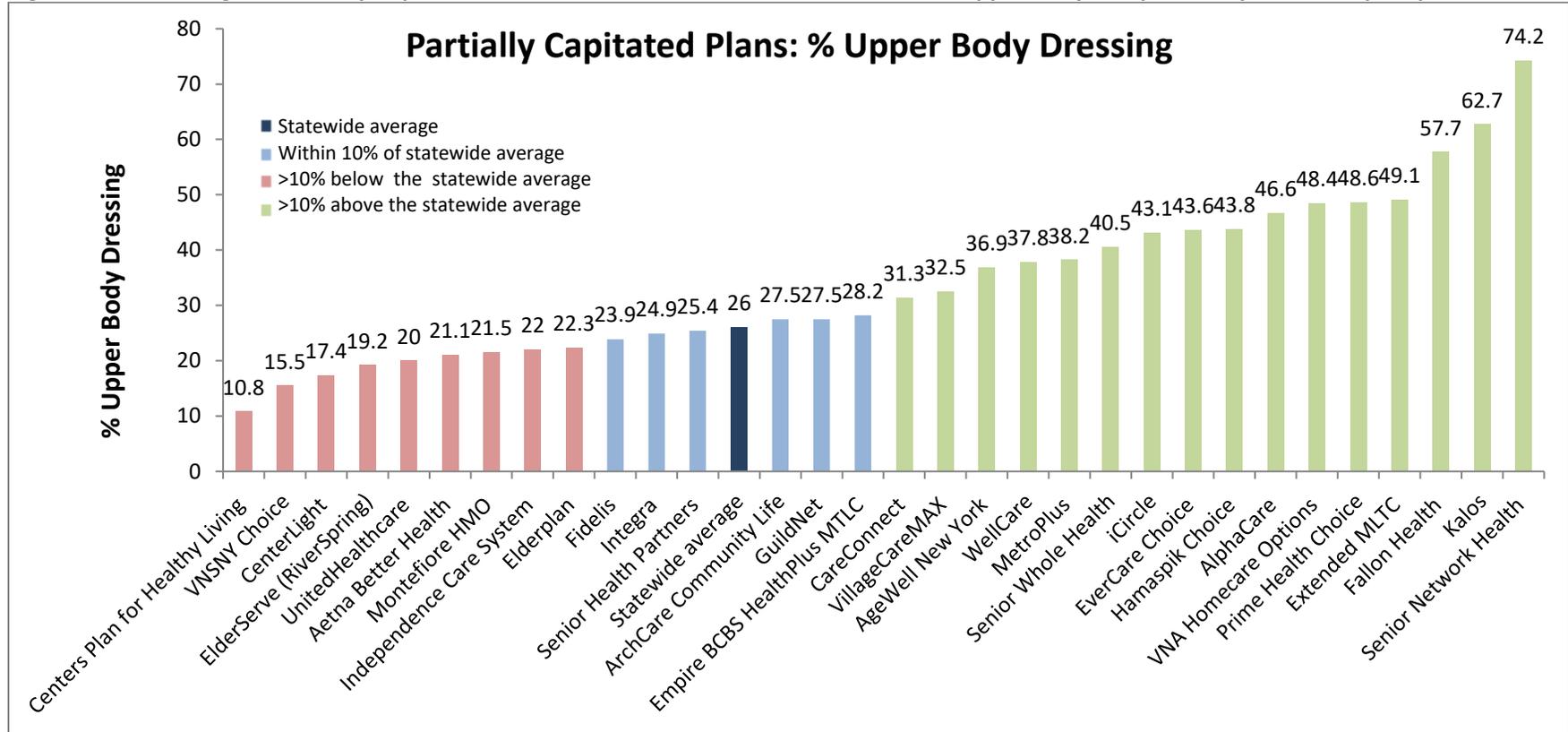


Upper Body Dressing

Partially Capitated

The statewide average for the **upper body dressing** indicator decreased one percentage point, from 27% to 26%, from the first reporting period to the second. As indicated in **Figure 7A** below, there were six plans that had rates within 10 percent of the statewide average and two of those plans had rates within five percent of the statewide average. Sixteen plans' rates for upper body dressing exceeded the statewide average by more than 10 percent. Conversely, nine plans' rates were greater than 10 percentage points below the statewide average.

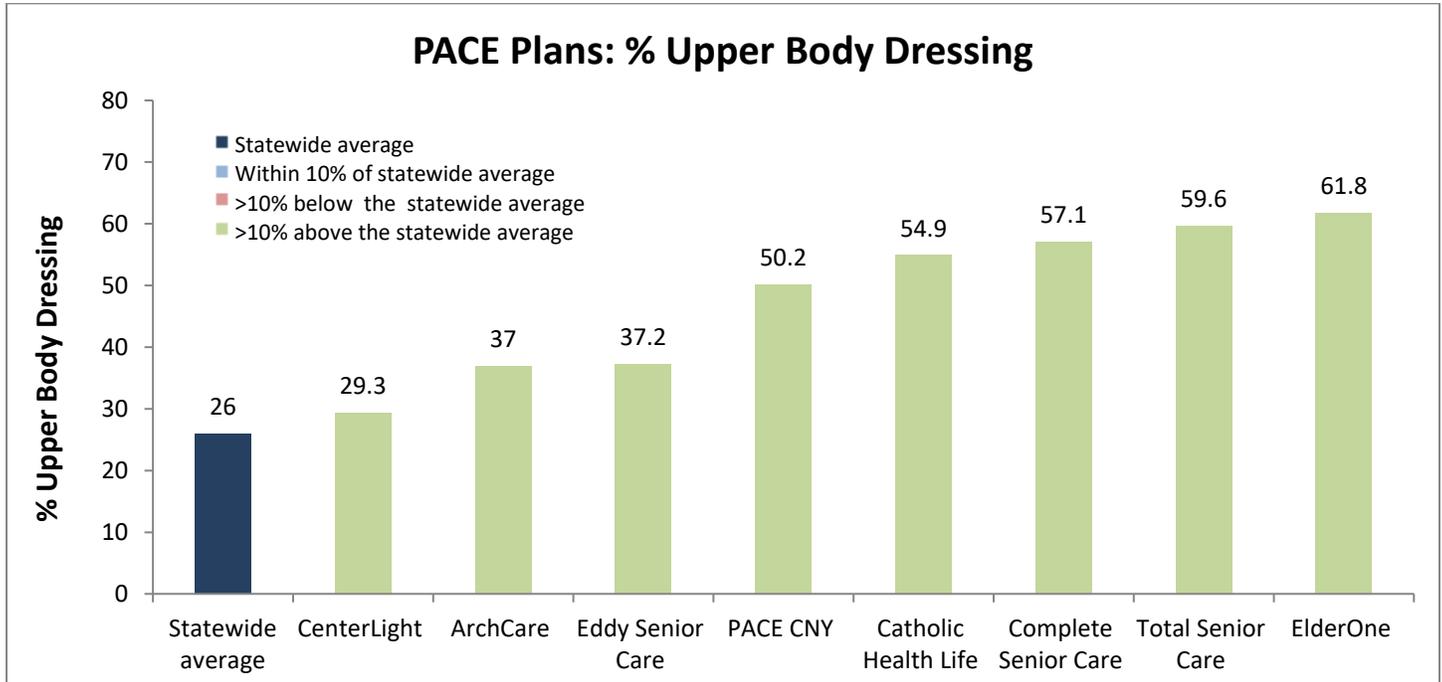
Figure 7A. Percentage of Partially Capitated members who dressed and undressed their upper body independently, with setup help, or under supervision.



PACE

The percentage of members who could perform **upper body dressing** decreased slightly from the first reporting period to the second (27% vs. 26%). Similar to bathing, all eight PACE plans had rates for this indicator that exceeded the statewide average by more than 10 percent, as seen in **Figure 7B**.

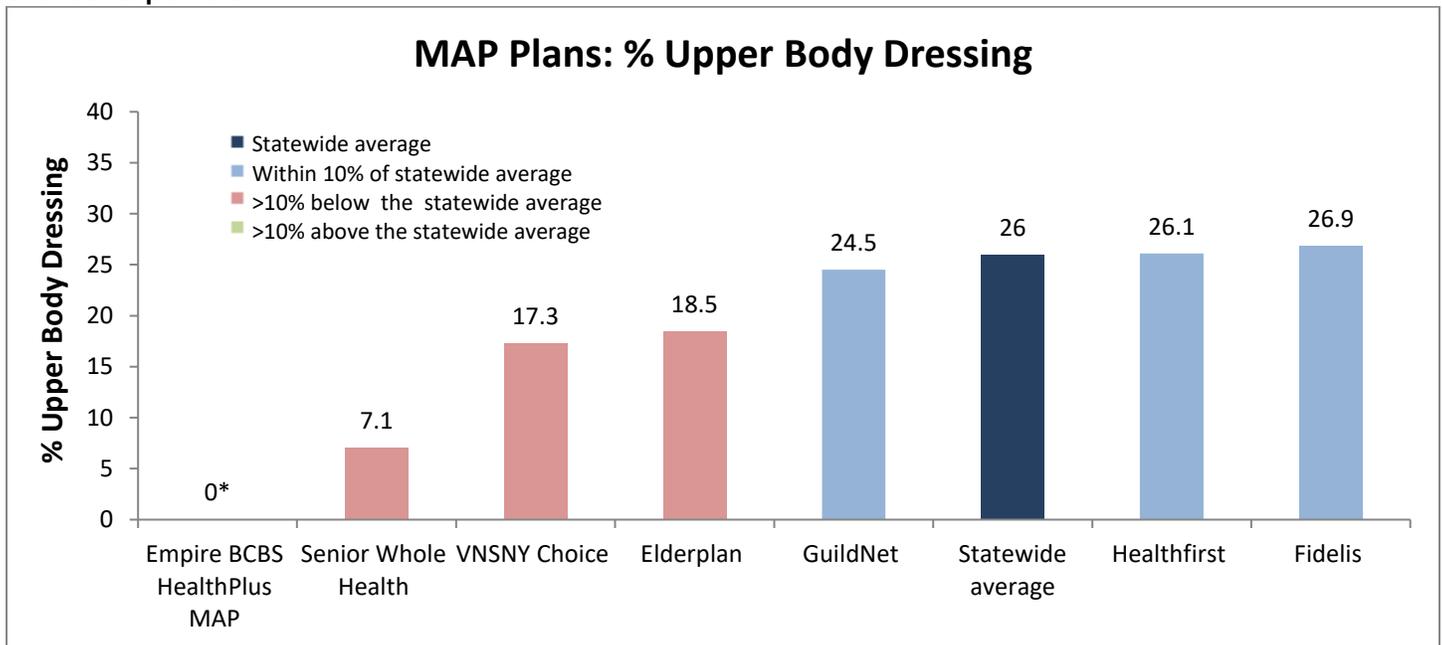
Figure 7B. Percentage of PACE members who dressed and undressed their upper body independently, with setup help, or under supervision.



MAP

The statewide average for **upper body dressing** decreased one percentage point to 26%. As shown in **Figure 7C** below, there were three plans that had rates within 10 percent of the statewide average and one of those plans had a rate that was within five percent of the statewide average. Four plans had rates that were more than 10 percent below the statewide average.

Figure 7C. Percentage of MAP members who dressed and undressed their upper body independently, with setup help, or under supervision.

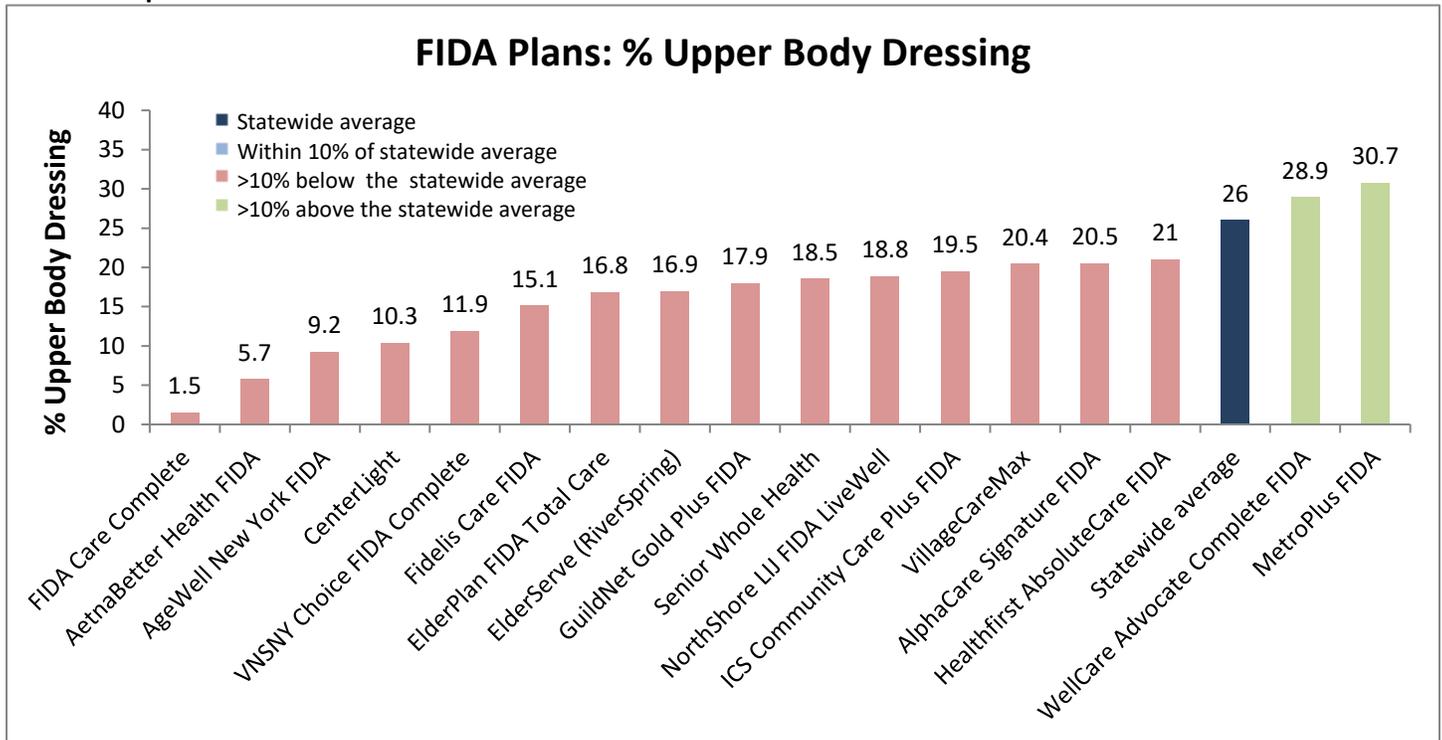


*Rate reflects data from one assessment completed.

FIDA

For **upper body dressing**, the statewide average decreased by one percentage point from 27% to 26% in the final reporting period. As shown in **Figure 7D** below, two FIDA plans had rates for this indicator that were more than 10 percent above the statewide average. Conversely, there were fifteen FIDA plans that had rates for upper body dressing that were more than 10 percent below the statewide average.

Figure 7D. Percentage of FIDA members who dressed and undressed their upper body independently, with setup help, or under supervision.

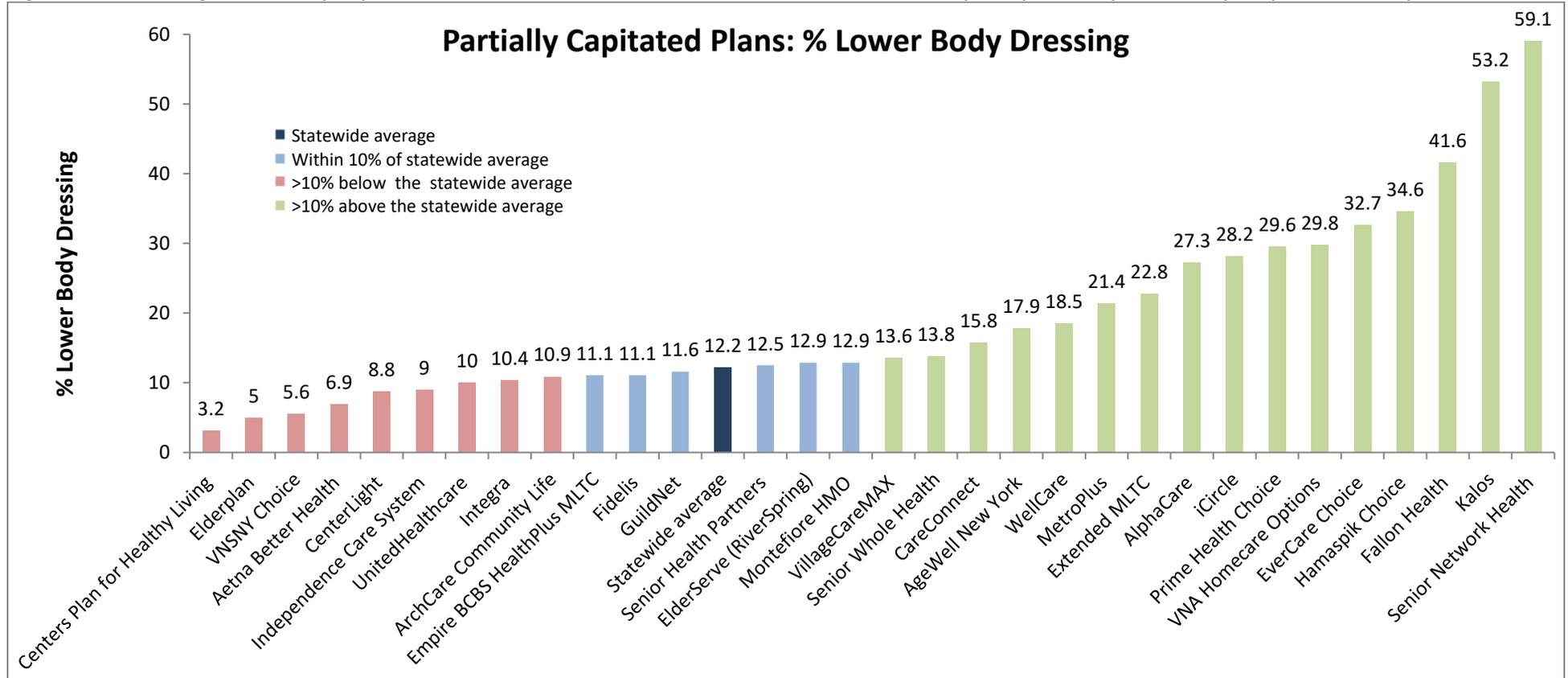


Lower Body Dressing

Partially Capitated

The statewide average for **lower body dressing** decreased one percentage point to 12.2% in July-December 2015. As indicated by **Figure 8A**, six plans had rates that were within 10 percent of the statewide average, of which two plans had rates that were within five percent of the statewide average. There were sixteen plans that had rates greater than 10 percent above the statewide average and there were nine plans that had rates for lower body dressing that were greater than 10 percent below the statewide average.

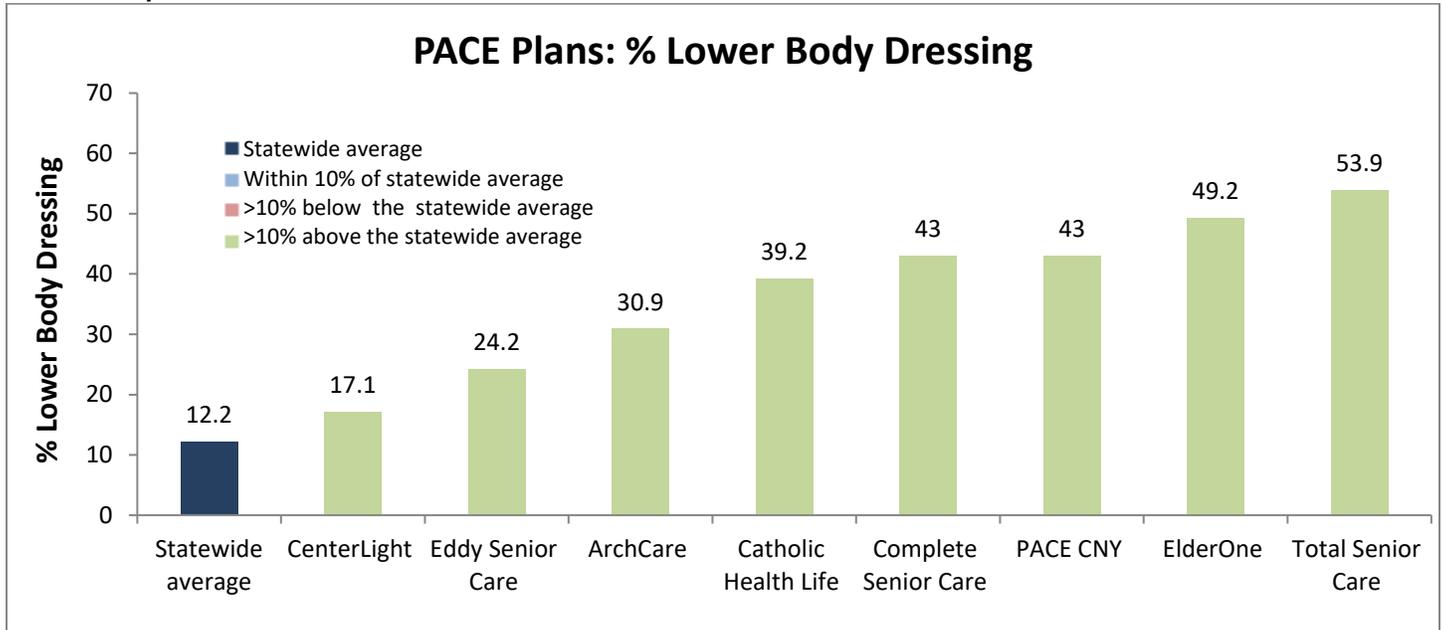
Figure 8A. Percentage of Partially Capitated members who dressed and undressed their lower body independently, with setup help, or under supervision.



PACE

The statewide average for **lower body dressing** decreased one percentage point to 12.2%. As shown in **Figure 8B**, all PACE plans had rates for this indicator that exceeded the statewide average by more than 10 percent.

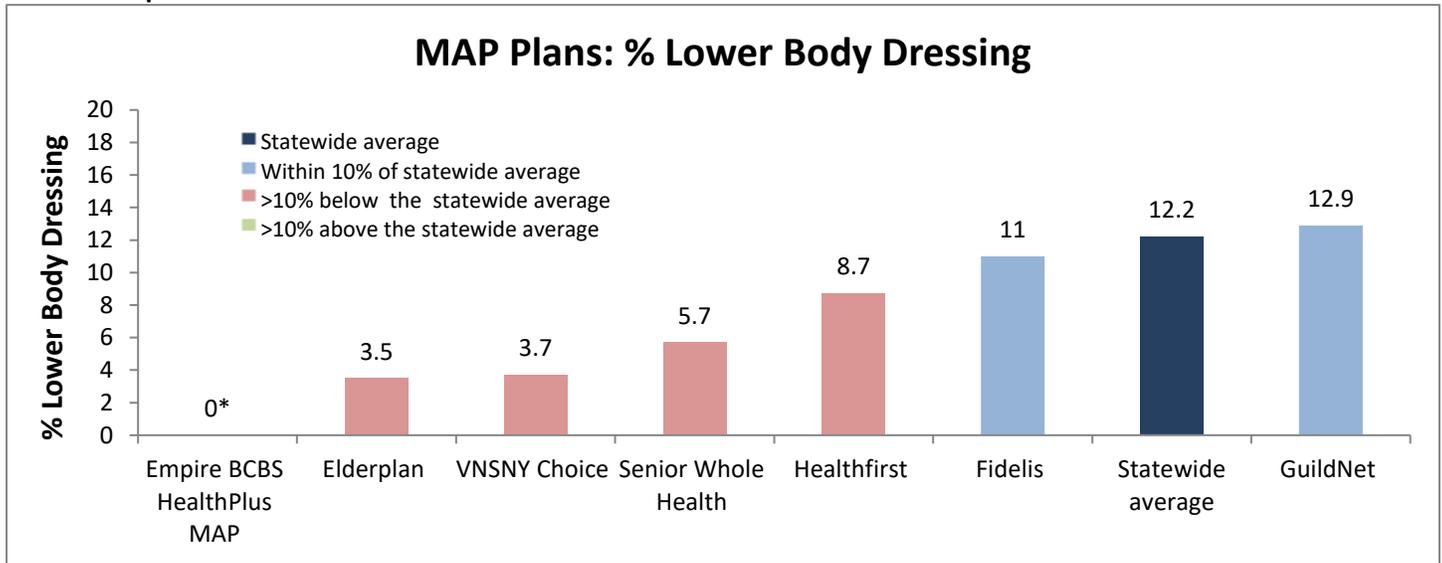
Figure 8B. Percentage of PACE members who dressed or undressed their lower body independently, with setup help, or under supervision.



MAP

For **lower body dressing**, the statewide average decreased by one percentage point to 12.2%. As shown in **Figure 8C** below, there were two MAP plans that had rates within 10 percent of the statewide average. The remaining five plans had rates that fell below the statewide average by more than 10 percent.

Figure 8C. Percentage of MAP members who dressed or undressed their lower body independently, with setup help, or under supervision.

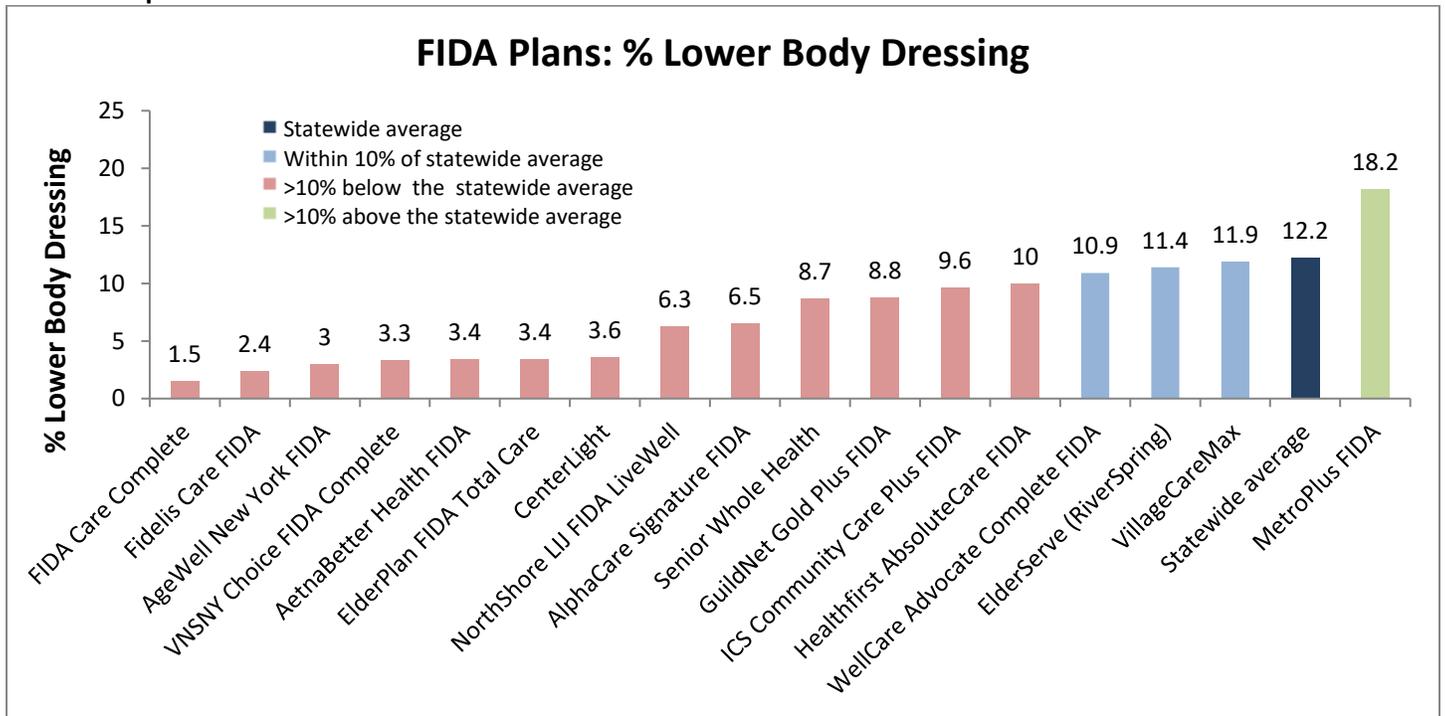


*Rate reflects data from one assessment completed.

FIDA

The statewide average for **lower body dressing** decreased one percentage point from 13.2% in the initial reporting period to 12.2% in the final reporting period. As indicated by **Figure 8D**, there were three plans that had rates for this indicator that were within 10 percent of the statewide average and one of those plans had a rate that was within five percent of the statewide average. While thirteen plans had rates that were below the statewide average by more than 10 percent, one plan’s rate fell above the statewide average by more than 10 percent.

Figure 8D. Percentage of FIDA members who dressed or undressed their lower body independently, with setup help, or under supervision.

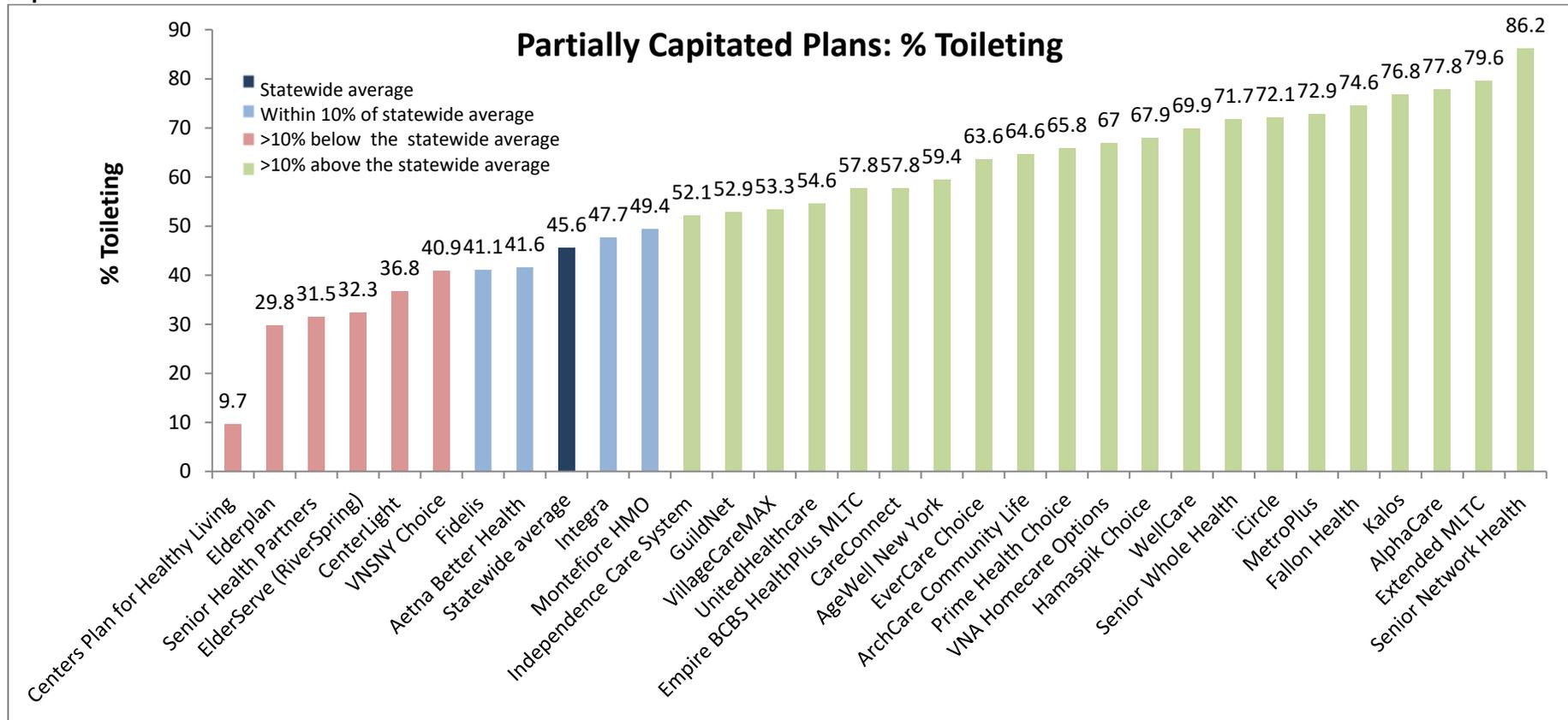


Toileting

Partially Capitated

The statewide average for the **toileting** indicator decreased 4.2 percentage points to 45.6% in July-December 2015. As indicated by **Figure 9A** below, there were four partially capitated plans whose rates were within 10 percent of the statewide average, one of which whose rate was within five percent of the statewide average. Twenty-one plans had rates that were greater than 10 percent above the statewide average, and six plans had rates that were greater than 10 percent below the statewide average.

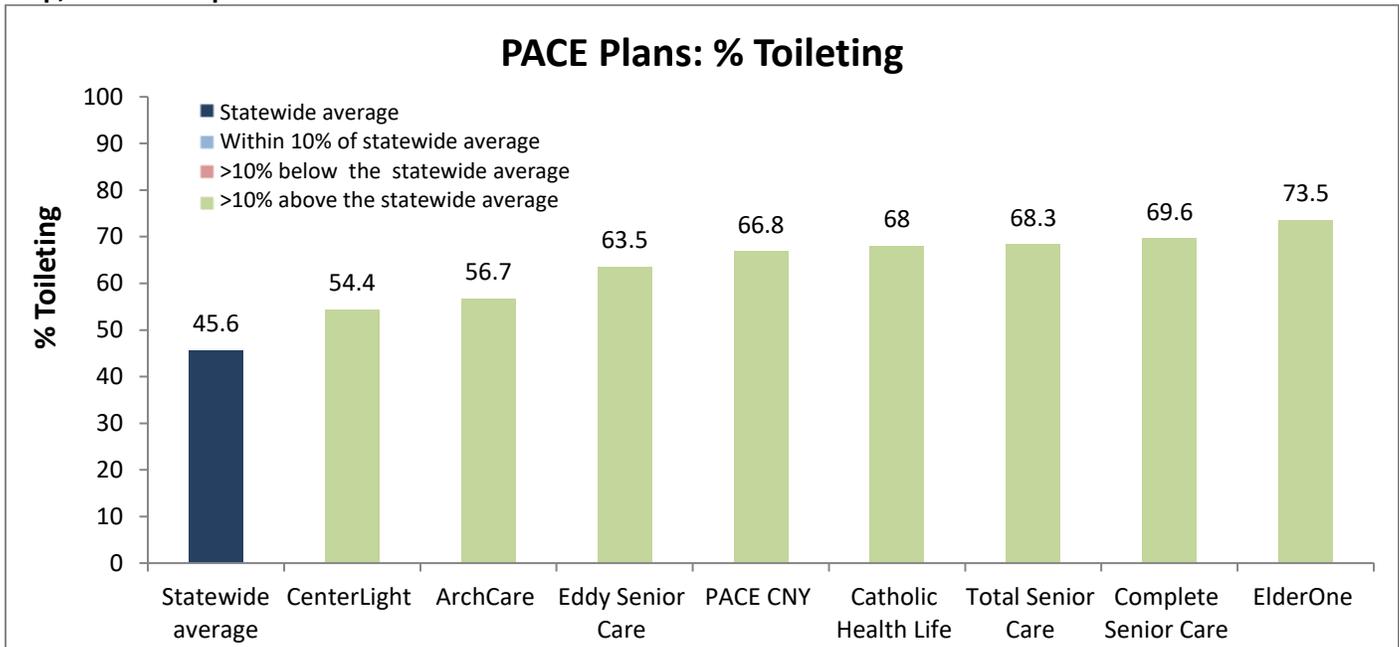
Figure 9A. Percentage of Partially Capitated members who used the toilet (or commode, bedpan, urinal) independently, with setup help, or under supervision.



PACE

The statewide average for the **toileting** indicator decreased 4.2 percentage points to 45.6%. As shown in **Figure 9B**, all PACE plans had rates for this indicator that exceeded the statewide average by more than 10 percent.

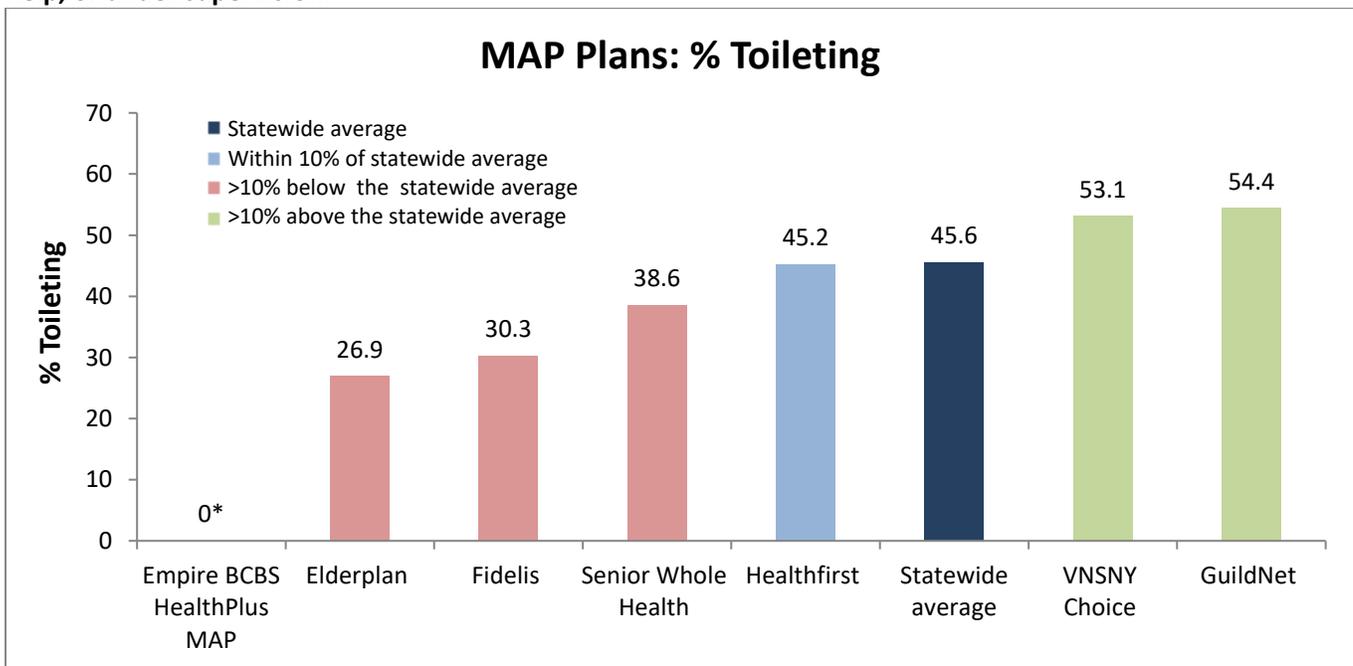
Figure 9B. Percentage of PACE members who used the toilet (or commode, bedpan, urinal) independently, with setup help, or under supervision.



MAP

For **toileting**, the statewide average decreased by 4.2 percentage points to 45.6% in July-December 2015. **Figure 9C** shows that one of the seven MAP plans had a rate that was within five percent of the statewide average. Four plans had rates that were greater than 10 percent below the statewide average, and two plans had rates for toileting that were greater than 10 percent above the statewide average.

Figure 9C. Percentage of MAP members who used the toilet (or commode, bedpan, urinal) independently, with setup help, or under supervision.

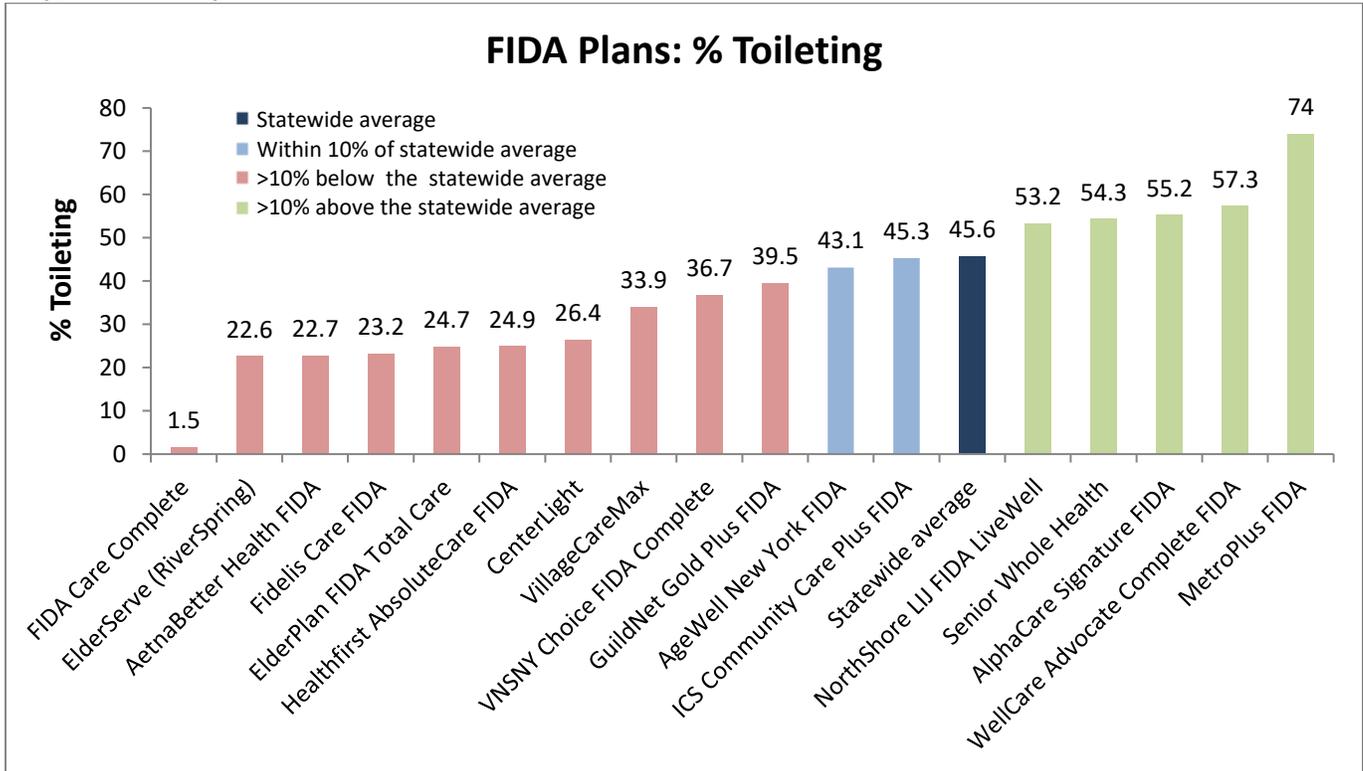


*Rate reflects data from one assessment completed.

FIDA

The statewide average for **toileting** decreased 4.2 percentage points to 45.6% in the final reporting period. According to **Figure 9D**, two FIDA plans had rates for this indicator that were within 10 percent of the statewide average, one of which had a rate that was within 5 percent of the statewide average. While ten plans had rates for toileting that fell more than 10 percent below the statewide average, five plans had rates that exceeded the statewide average for toileting by more than 10 percent.

Figure 9D. Percentage of FIDA members who used the toilet (or commode, bedpan, urinal) independently, with setup help, or under supervision.

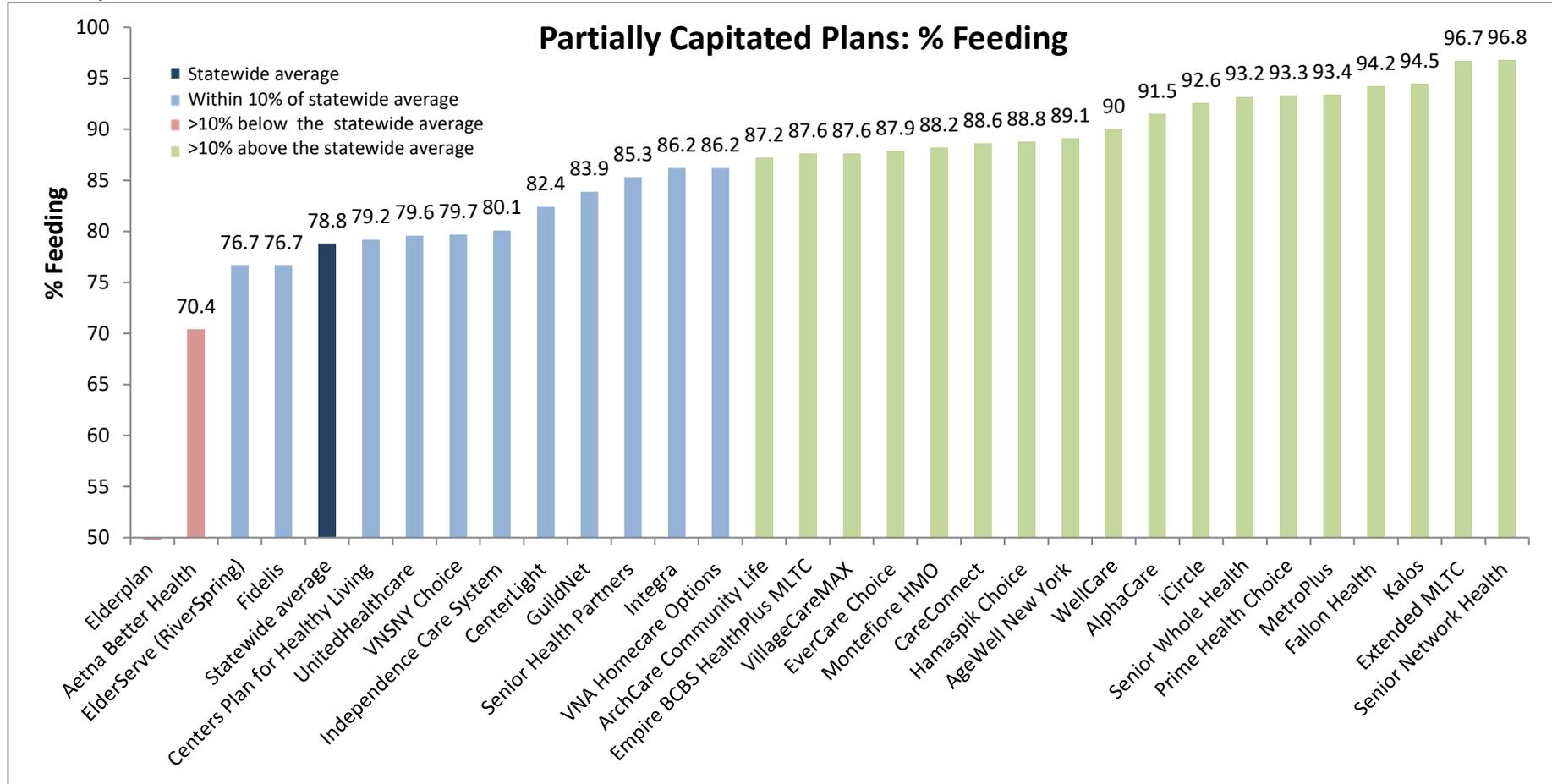


Feeding

Partially Capitated

For the **feeding** indicator, the statewide average decreased from the first reporting period to the second (80.7% vs. 78.8%). As indicated by **Figure 10A**, there were eleven partially capitated plans that had rates within 10 percent of the statewide average and of those plans, seven plans had rates within five percent of the statewide average. While eighteen plans had rates that exceeded the statewide average by more than 10 percent, two plans had rates for this indicator that were more than 10 percent below the statewide average.

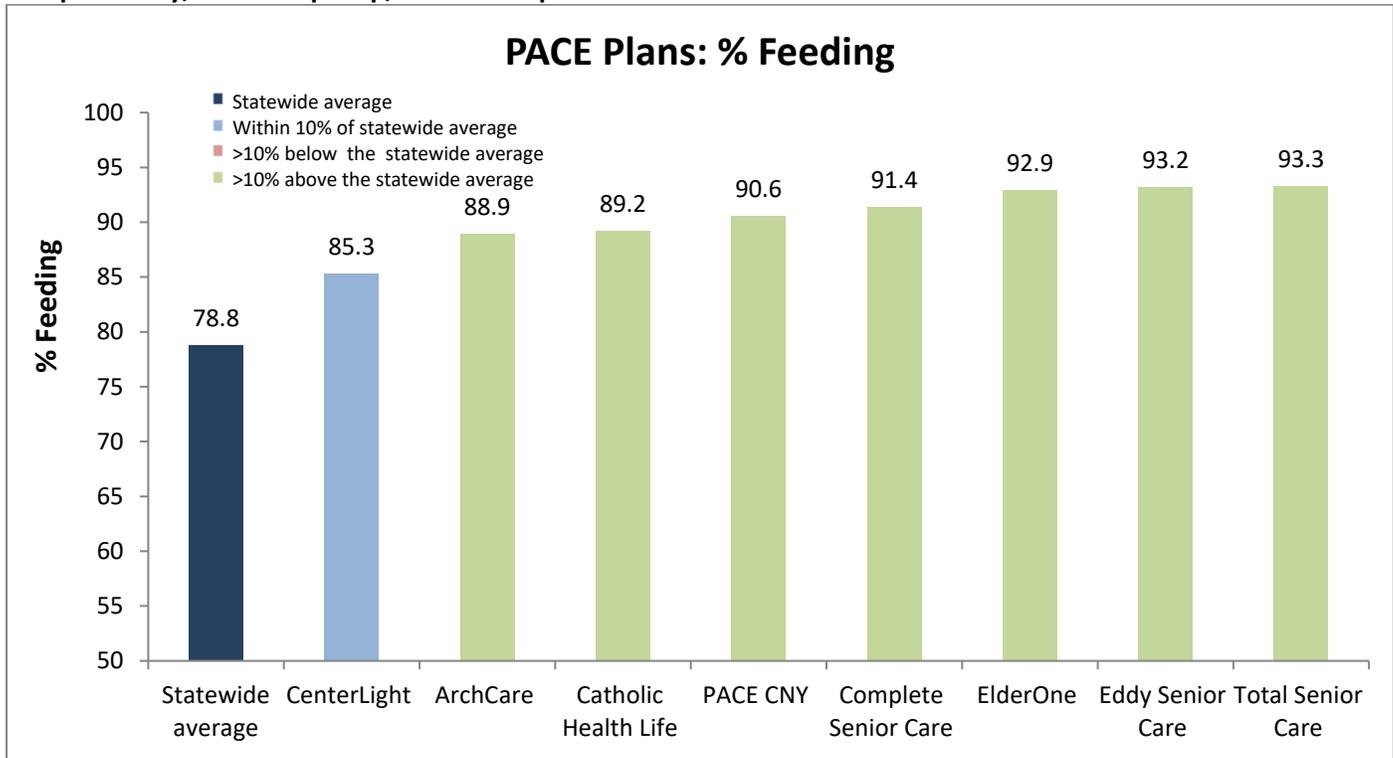
Figure 10A. Percentage of Partially Capitated members who ate and drank (including intake of nutrition by other means) independently, with setup help, or under supervision.



PACE

The statewide average for **feeding** decreased by 1.9 percentage points to 78.8%. While seven PACE plans had rates that exceeded this average by more than 10 percent, one plan's rate was within 10 percent of the statewide average, as shown in **Figure 10B**.

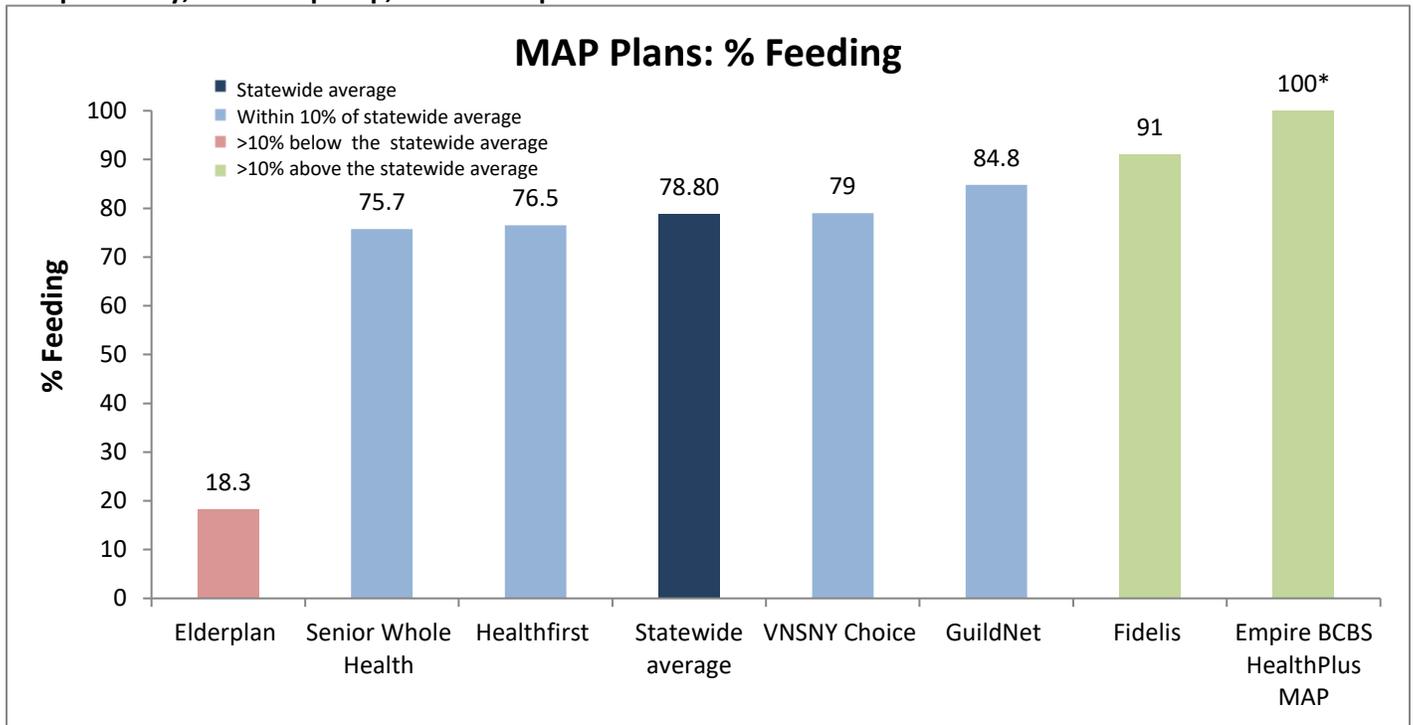
Figure 10B. Percentage of PACE member who ate and drank (including intake of nutrition by other means) independently, with setup help, or under supervision.



MAP

For **feeding**, the statewide average decreased by 1.9 percentage points to 78.8%. Shown in **Figure 10C**, there were four MAP plans that had rates for this indicator that were within 10 percent of the statewide average; with one of those four falling within five percent of the statewide average, and therefore within 10 percent of the statewide average. While two plans had rates that exceeded the statewide average by more than 10 percent, one plan's rate was below the statewide average by more than 10 percent.

Figure 10C. Percentage of MAP members who ate and drank (including intake of nutrition by other means) independently, with setup help, or under supervision.

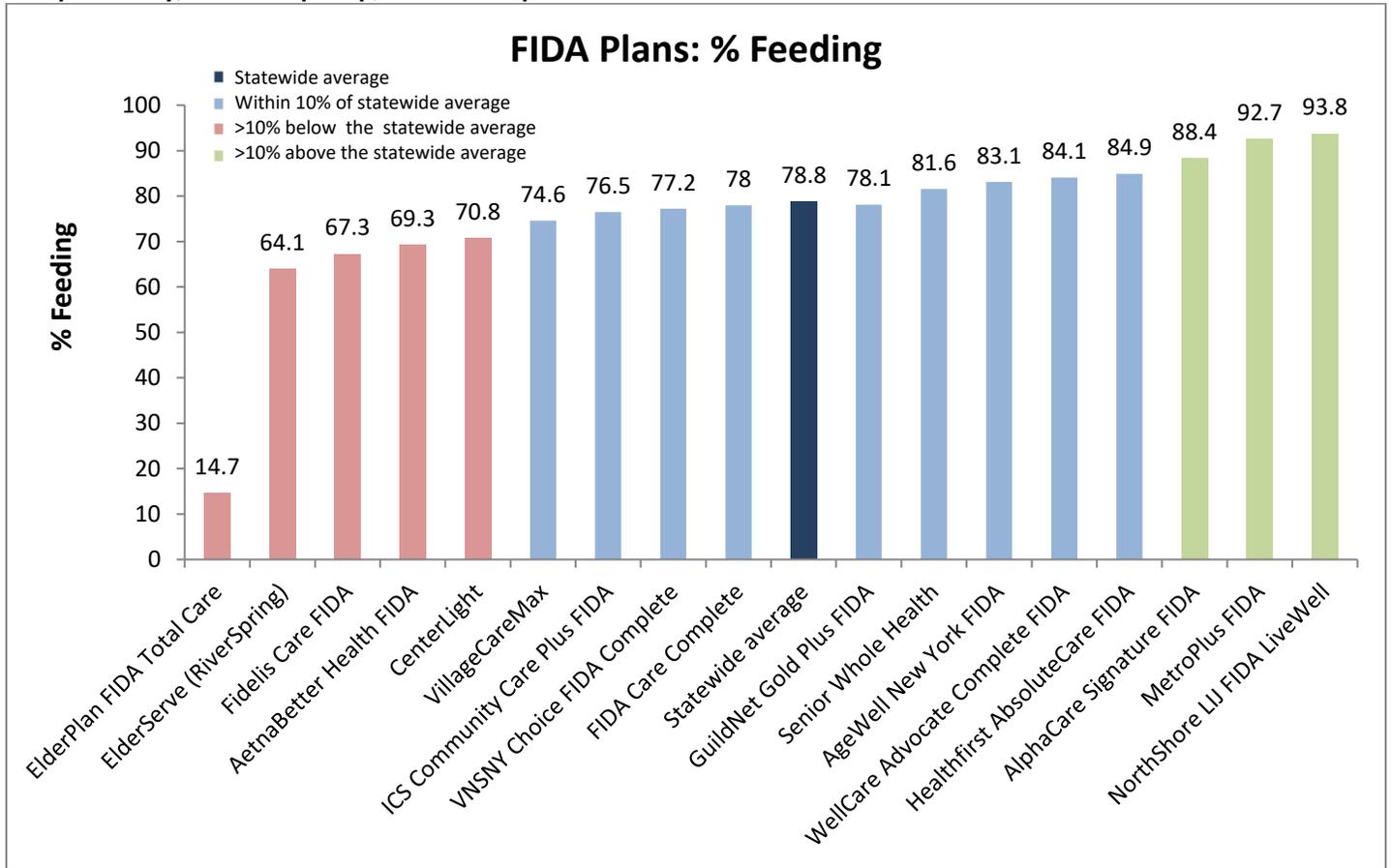


*Rate reflects data from one assessment completed.

FIDA

The statewide average for **feeding** decreased by 1.9 percentage points to 78.8%. As illustrated in **Figure 10D** below, there were nine FIDA plans that had rates for this indicator that were within 10 percent of the statewide average and five of those plans had rates within five percent of the statewide average. Three plans had rates that were greater than 10 percent above the statewide average. Conversely, five plans had rates that were greater than 10 percent below the statewide average.

Figure 10D. Percentage of FIDA members who ate and drank (including intake of nutrition by other means) independently, with setup help, or under supervision.



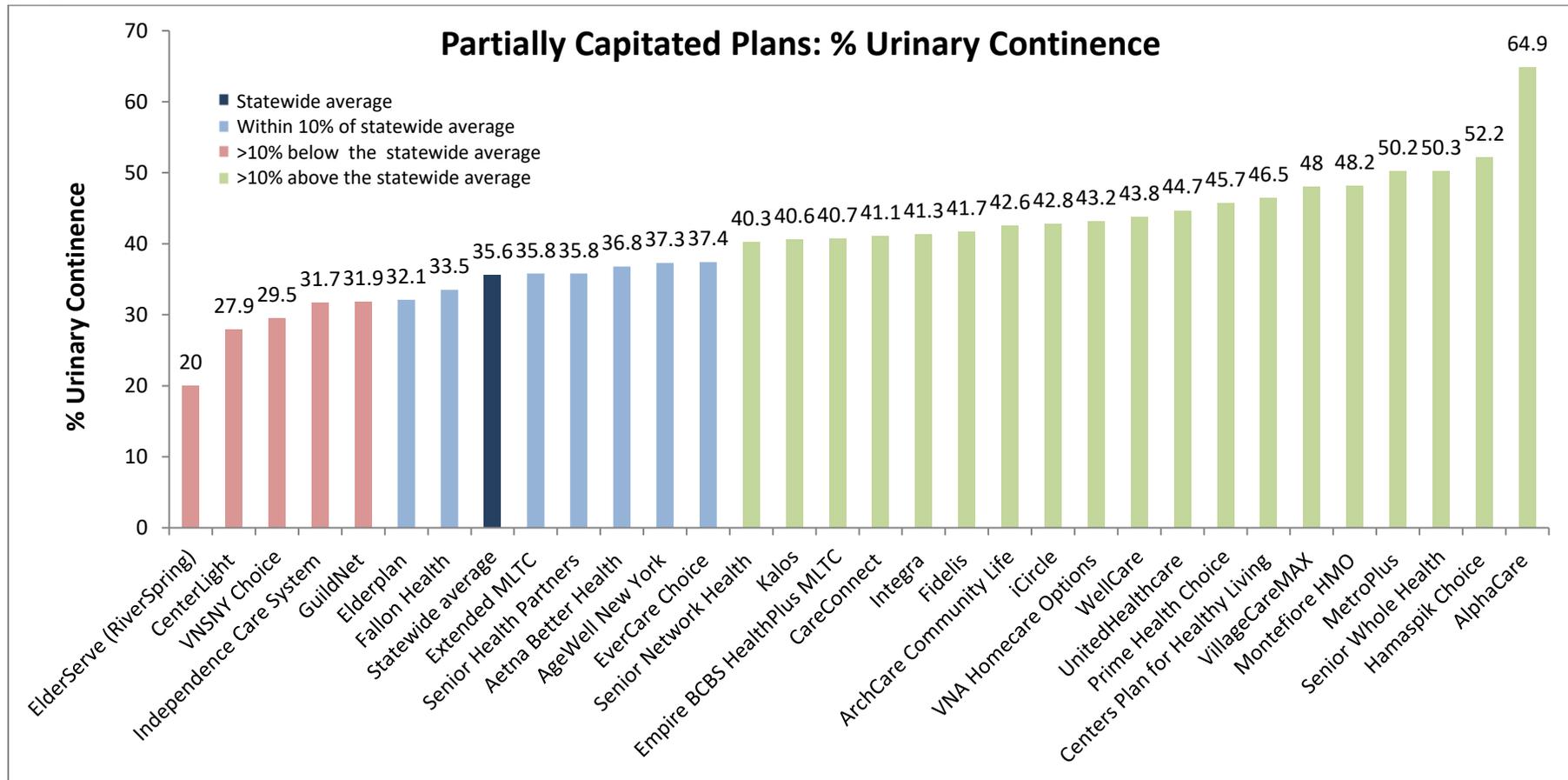
Physical Health Indicators

Urinary Continence

Partially Capitated

The statewide average for **urinary continence** remained unchanged between both reporting periods at 35.6%. As indicated by **Figure 11A** below, seven partially capitated plans had rates for this indicator that were within 10 percent of the statewide average, of which four plans had rates that were within five percent of the statewide average. There were nineteen plans that had rates that exceeded the statewide average by more than 10 percent. Conversely, five plans had rates that were below the statewide average by more than 10 percent.

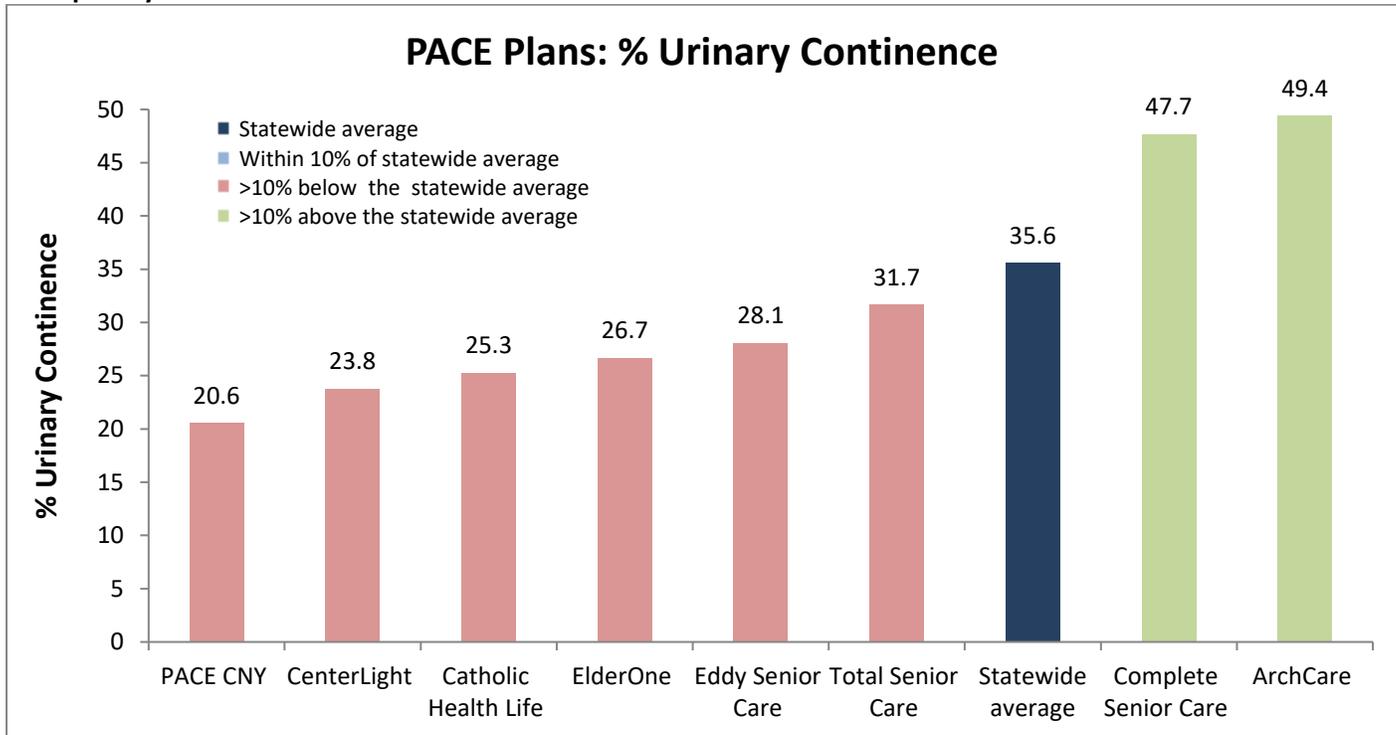
Figure 11A. Percentage of Partially Capitated members who were continent, had control with any catheter or ostomy, or were infrequently incontinent of urine.



PACE

The statewide average for **urinary continence** remained the same from January-June to July-December at 35.6%. Six PACE plans had rates that were greater than 10 percent below the statewide average, and two plans had rates that exceeded the statewide average by more than 10 percent, as shown in **Figure 11B**.

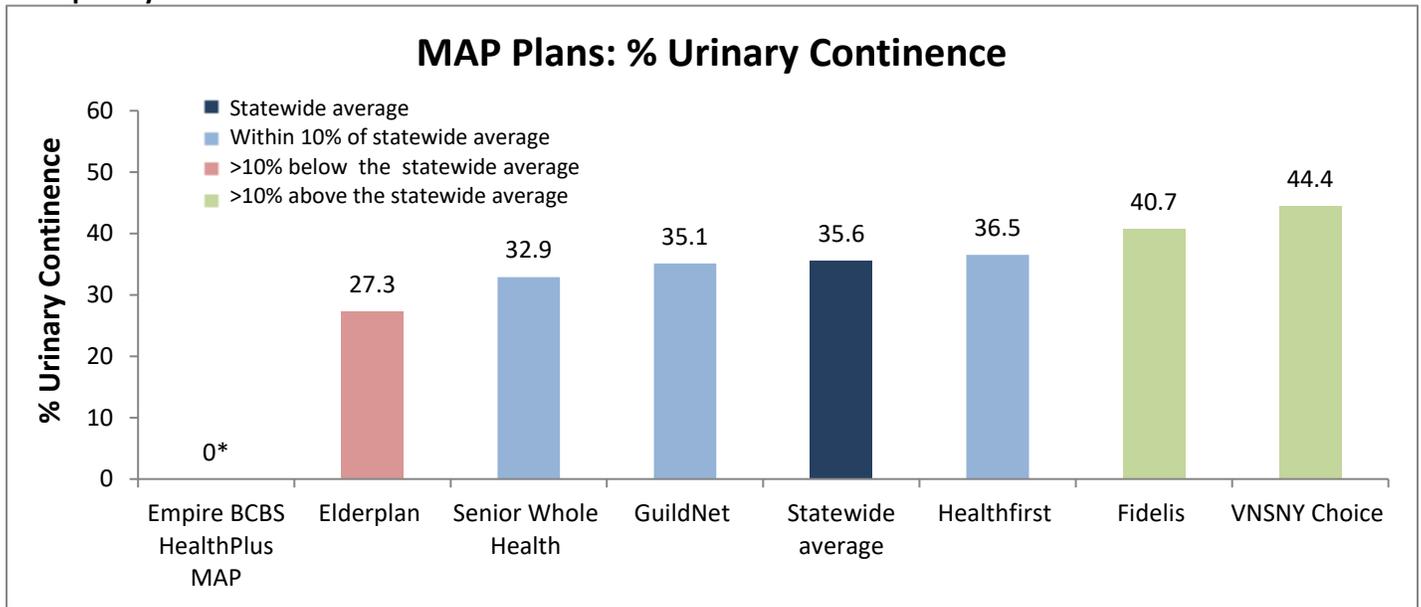
Figure 11B. Percentage of PACE members who were continent, had control with any catheter or ostomy, or were infrequently incontinent of urine.



MAP

The statewide average for **urinary continence** remained unchanged at 35.6%. As indicated in **Figure 11C**, there were three MAP plans that had rates for this indicator that were within 10 percent of the statewide average; two of these plans had rates that were within five percent of the statewide average. Two plans had rates for urinary continence that were more than 10 percent above the statewide average and two plans had rates for this indicator that were greater than 10 percent below the statewide average.

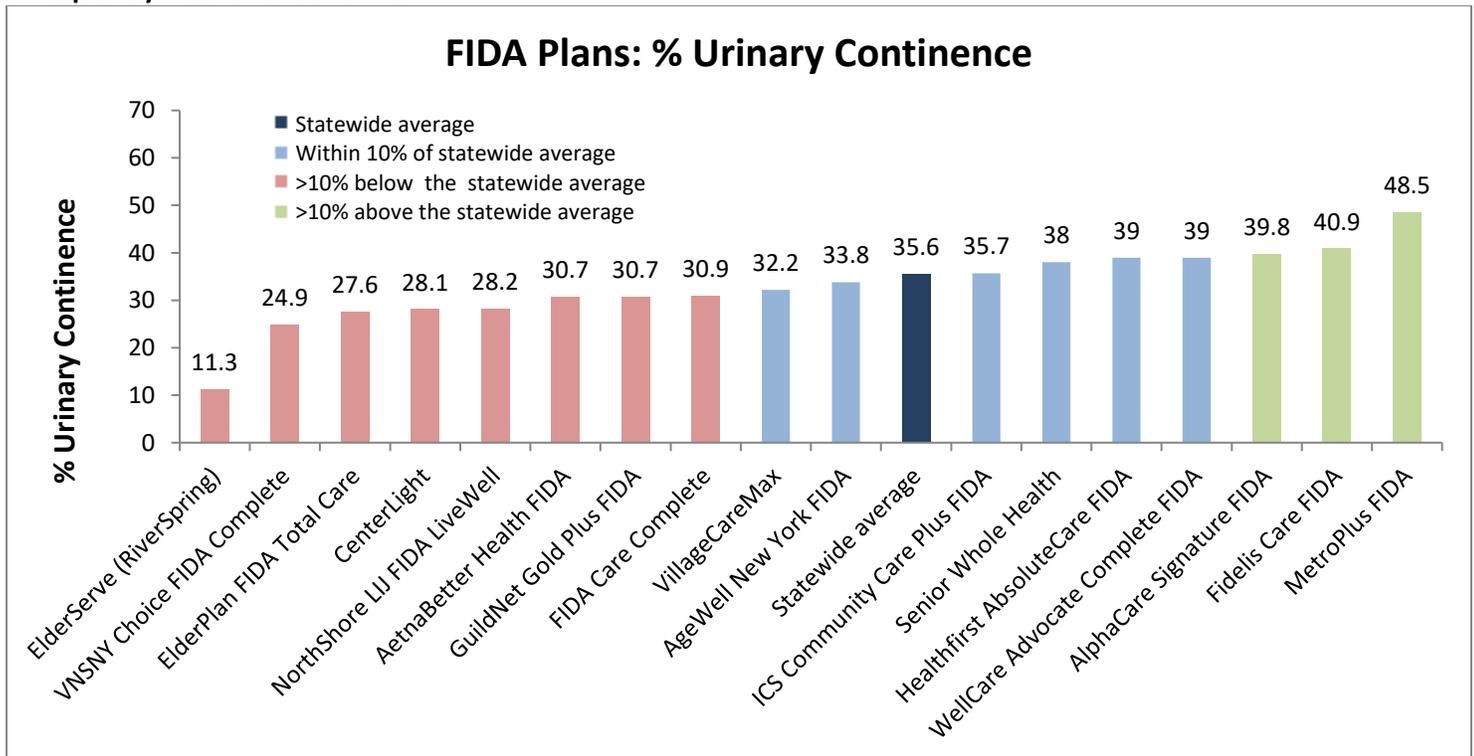
Figure 11C. Percentage of MAP members who were continent, had control with any catheter or ostomy, or were infrequently incontinent of urine.



*Rate reflects data from one assessment completed.

FIDA
 The statewide average for **urinary continence** remained unchanged from the initial to the final reporting period at 35.6%. As shown in **Figure 11D**, there were six FIDA plans that had rates for this indicator in the final reporting period that were within 10 percent of the statewide average and two of those plans had rates within 5 percent of the statewide average. While eight plans had rates that were greater than 10 percent below the statewide average, three plans had rates that were greater than 10 percent above the statewide average.

Figure 11D. Percentage of FIDA members who were continent, had control with any catheter or ostomy, or were infrequently incontinent of urine.

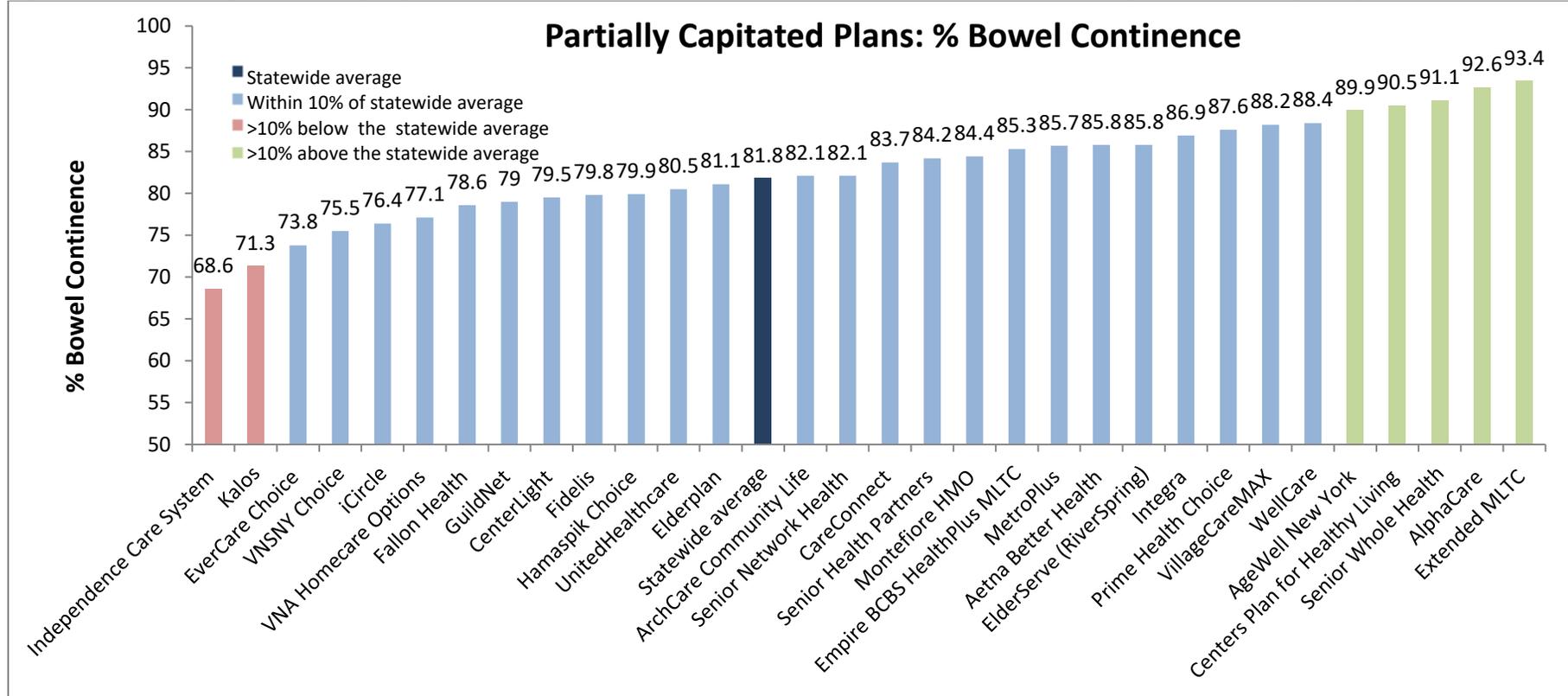


Bowel Continence

Partially Capitated

For the **bowel continence** indicator, the statewide average decreased slightly from 82.4% to 81.8% from the January 2015-June 2015 reporting period to the July 2015-December 2015 reporting period. Twenty-four partially capitated plans had rates for this indicator that were within 10 percent of the statewide average and seventeen of those plans had rates within five percent of the statewide average, as indicated by **Figure 12A**. There were two plans whose rates were below the statewide average by more than 10 percent and five plans whose rates for bowel continence were above the statewide average by more than 10 percent.

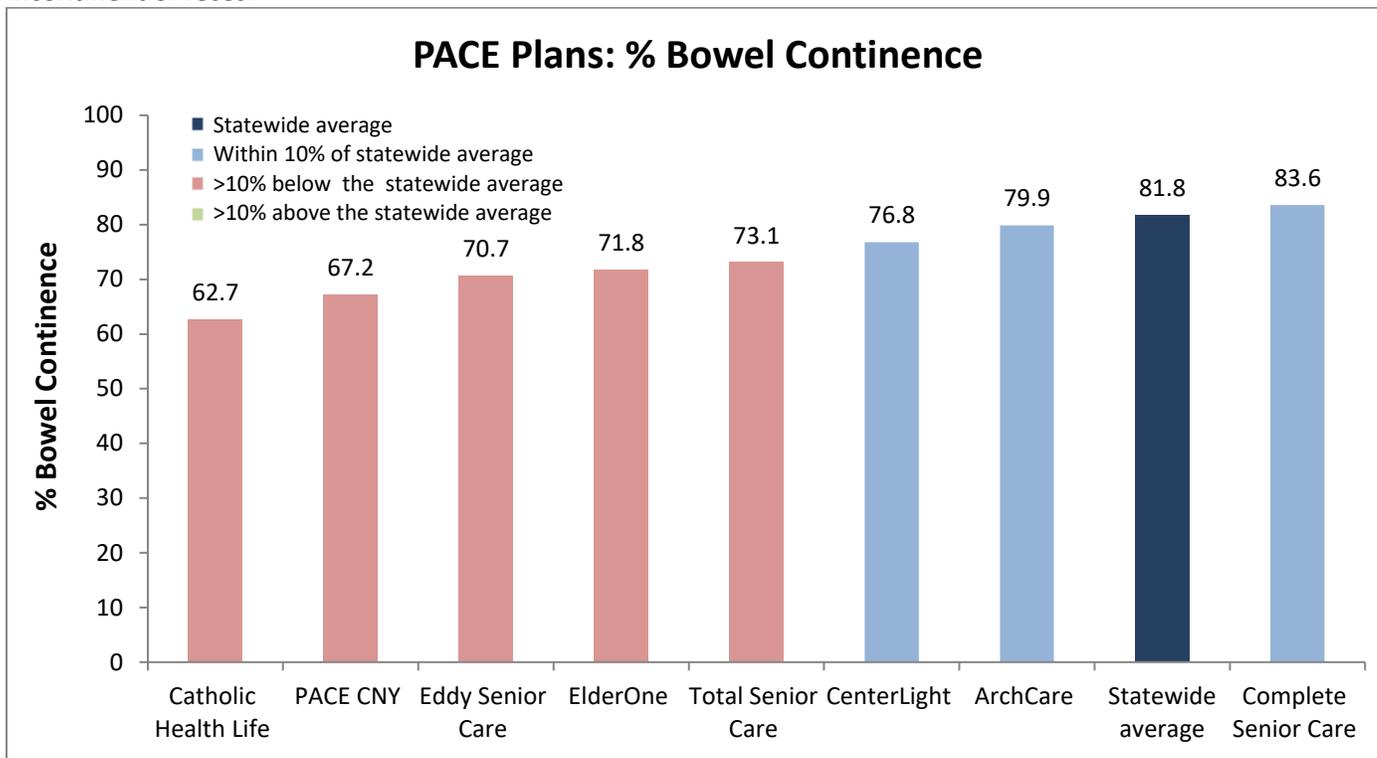
Figure 12A. Percentage of Partially Capitated members who were continent, had bowel control with ostomy, or were infrequently incontinent of feces.



PACE

The statewide average for **bowel continence** decreased slightly to 81.8%. As shown in **Figure 12B**, three PACE plans had rates that were within 10 percent of the statewide average and two of those plans had rates within five percent of the statewide average. Of note, five plans had rates that were greater than 10 percent below the statewide average.

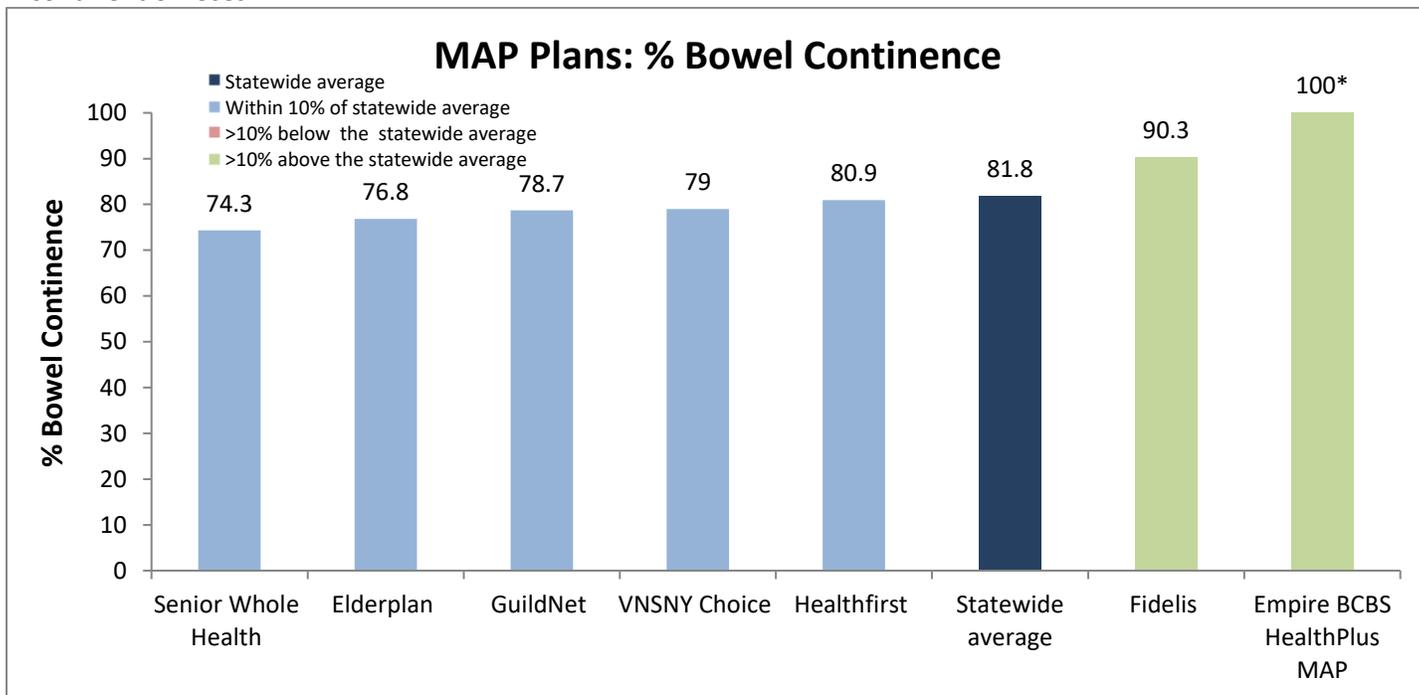
Figure 12B. Percentage of PACE members who were continent, had bowel control with ostomy, or were infrequently incontinent of feces.



MAP

For **bowel continence**, the statewide average decreased slightly by 0.6 percentage points to 81.8%. As indicated in **Figure 12C**, five MAP plans had rates that were within 10 percent of the statewide average. Of those plans, three plans had rates that were within five percent of the statewide average for bowel continence. Of note, two plans had rates that exceeded the statewide average for bowel continence by more than 10 percent.

Figure 12C. Percentage of MAP members who were continent, had bowel control with ostomy, or were infrequently incontinent of feces.

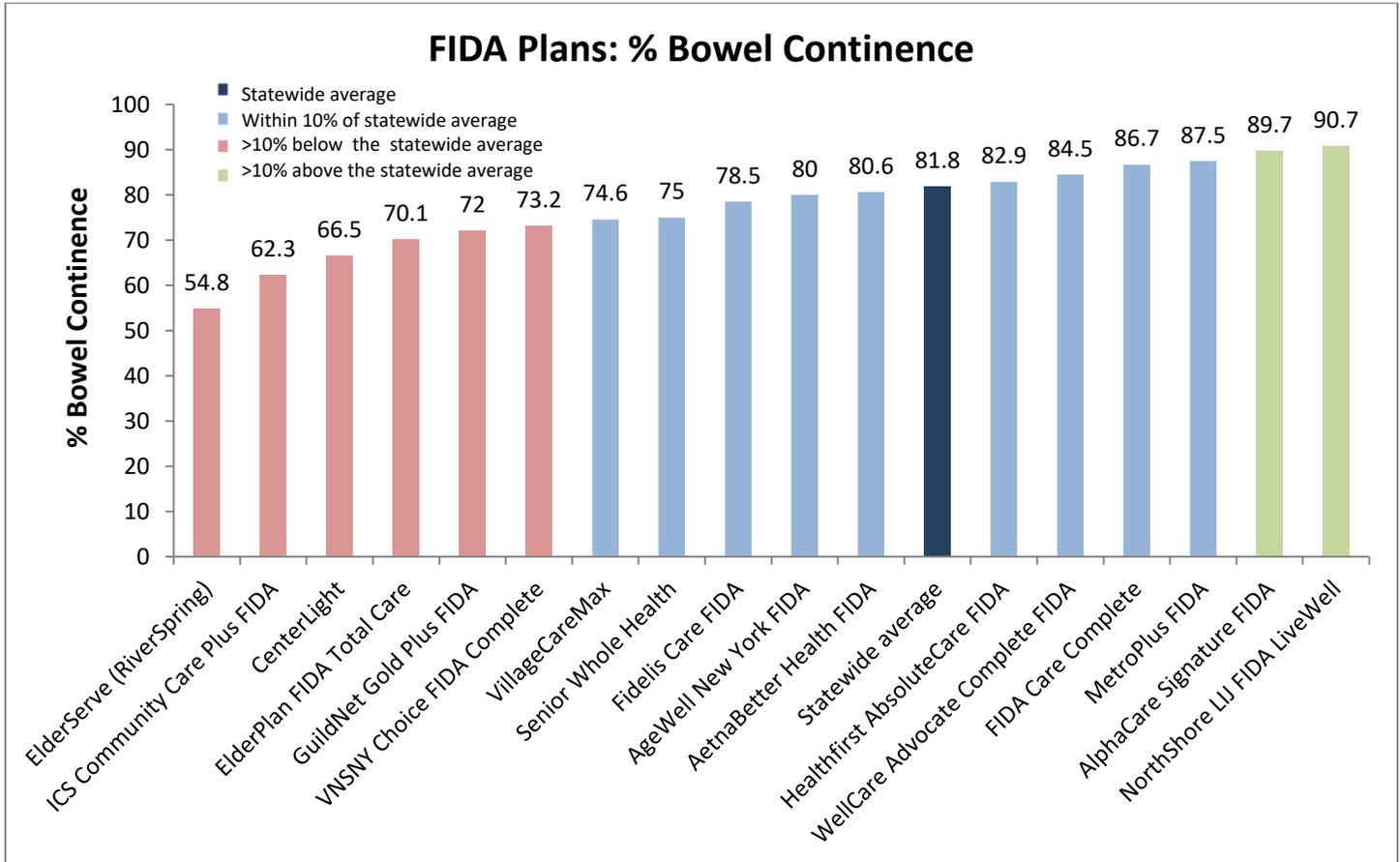


*Rate reflects data from one assessment completed.

FIDA

The statewide average for **bowel continence** decreased slightly from 82.4% to 81.8%. As seen **Figure 12D** below, there were nine FIDA plans that had rates for this indicator that were within 10 percent of the statewide average and five of which had rates within five percent of the statewide average. Two plans had rates that were more than 10 percent above the statewide average. Conversely, six plans had rates for bowel continence that were greater than 10 percent below the statewide average.

Figure 12D. Percentage of FIDA members who were continent, had bowel control with ostomy, or were infrequently incontinent of feces.

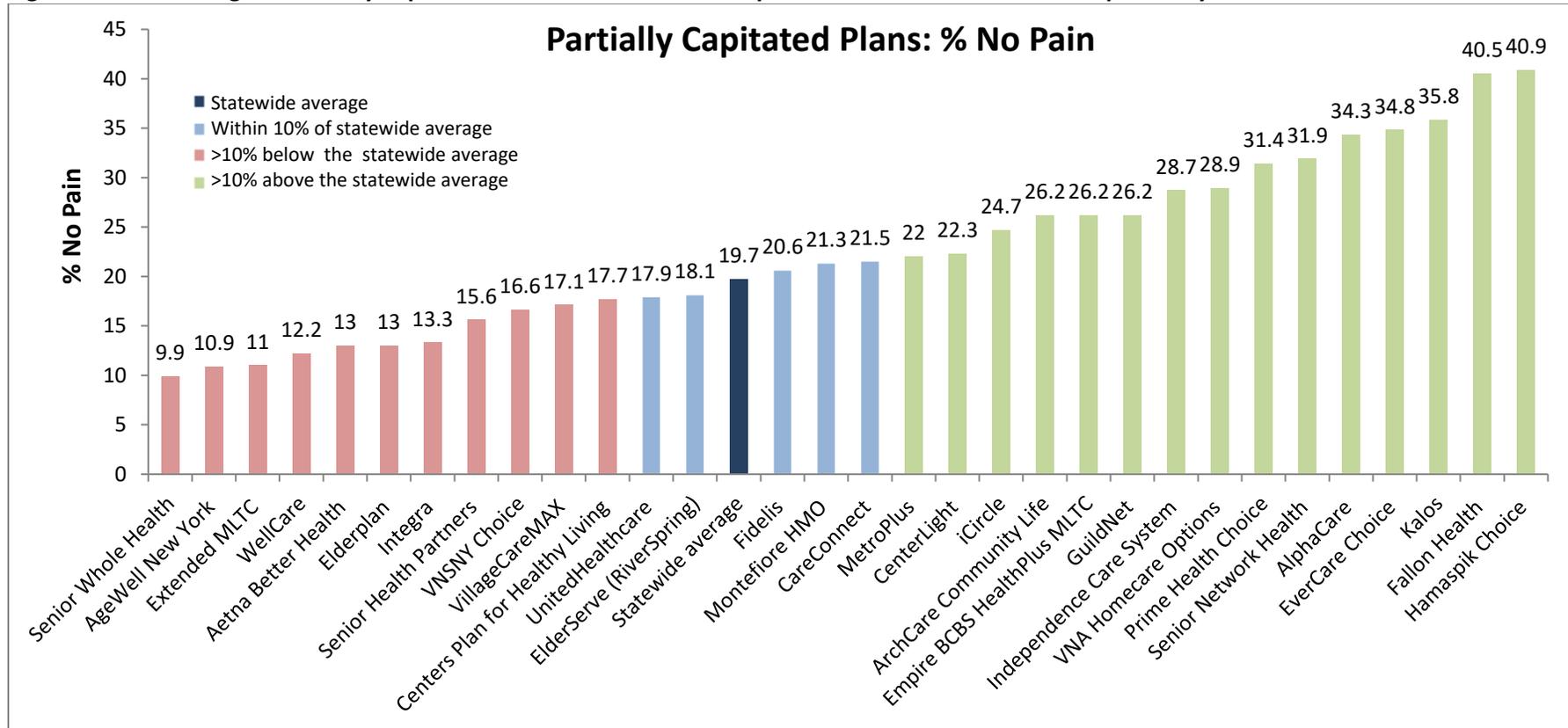


No Severe Daily Pain

Partially Capitated

Approximately the same percentage of members statewide indicated they experienced **no severe daily pain** when comparing the two 2015 reporting periods (19.9% vs. 19.7%). As indicated in **Figure 13A**, there were five partially capitated plans that had rates for this indicator within 10 percent of the statewide average, and one of those plans had a rate that fell within five percent of the statewide average. Fifteen plans had rates for pain that exceeded the statewide average by more than 10 percent. Conversely, eleven plans had rates for pain that were greater than 10 percent below the statewide average.

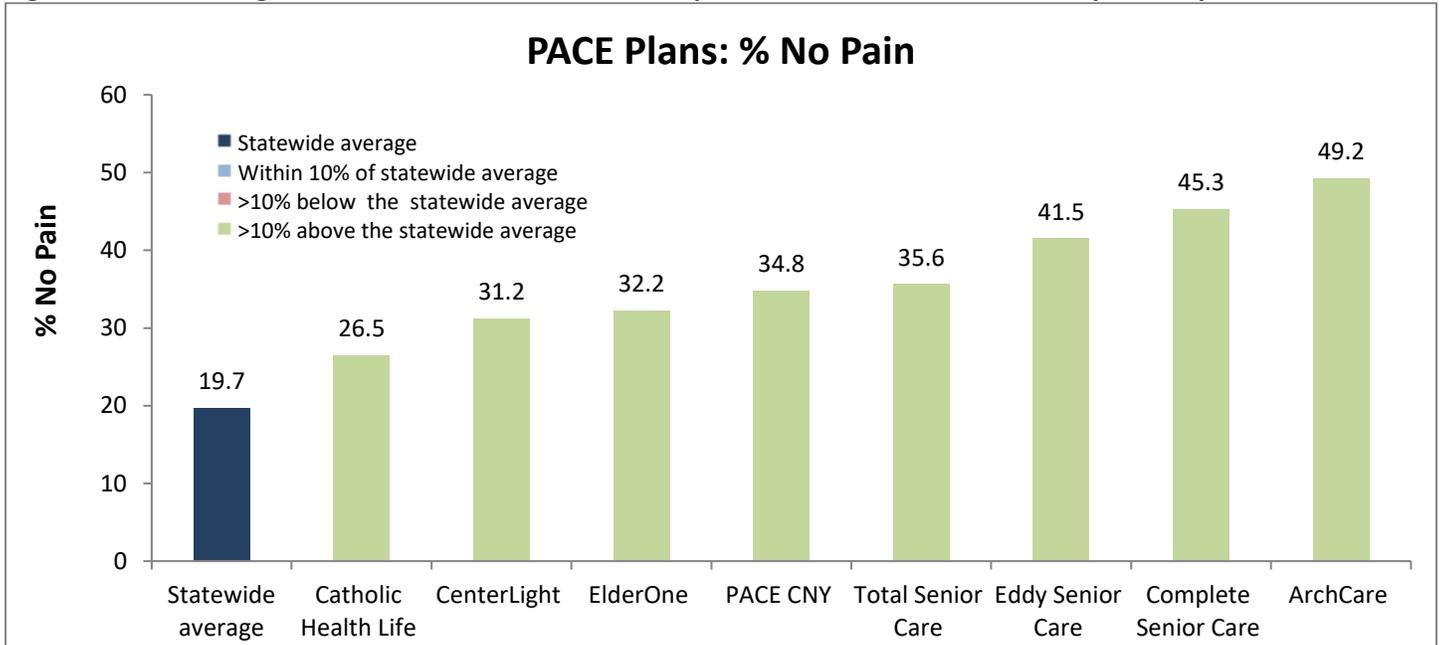
Figure 13A. Percentage of Partially Capitated members who did not experience severe or more intense pain daily.



PACE

The percentage of members statewide that indicated **no severe daily pain** remained virtually unchanged at 19.7%. All PACE plans had rates for this indicator that were greater than 10 percent above the statewide average for pain, as illustrated in **Figure 13B**.

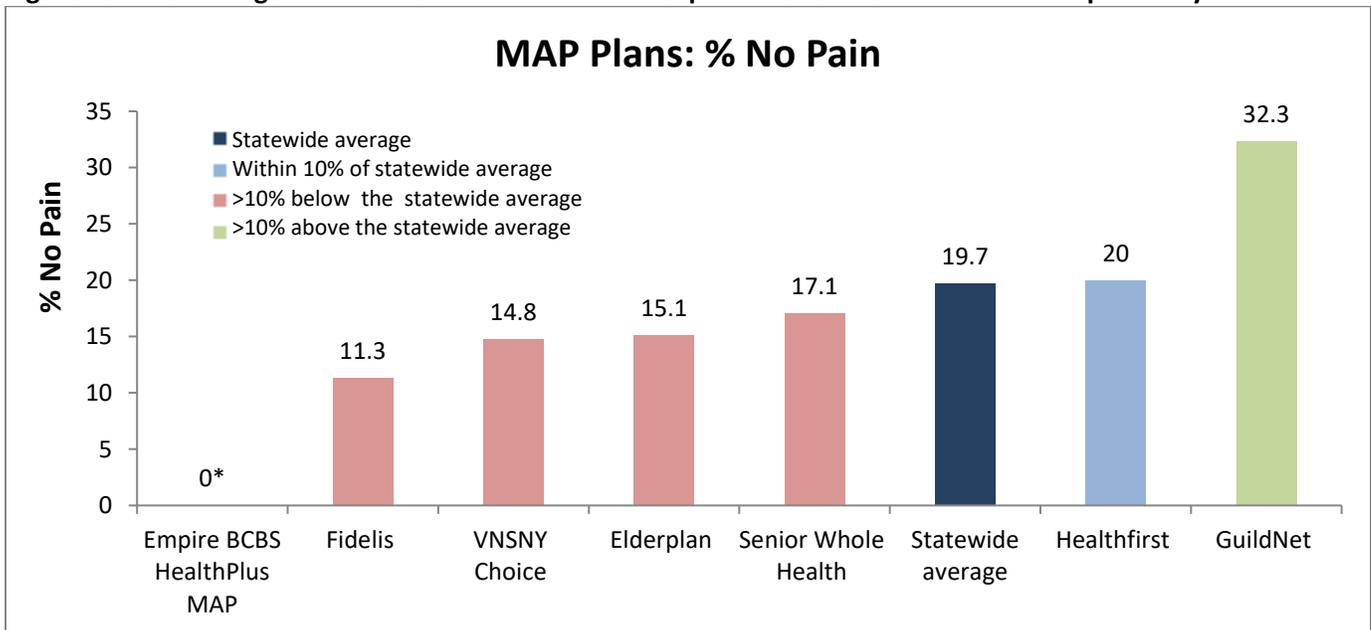
Figure 13B. Percentage of PACE members who did not experience severe or more intense pain daily.



MAP

The percentage of members statewide that indicated **no severe daily pain** remained virtually unchanged at 19.7%. There was one plan whose rate for this indicator was within five percent of the statewide average, as indicated in **Figure 13C**. While one plan’s rate for pain was above the statewide average by more than 10 percent, the remaining five MAP plans had rates below 10 percent of the statewide average.

Figure 13C. Percentage of MAP members who did not experience severe or more intense pain daily.

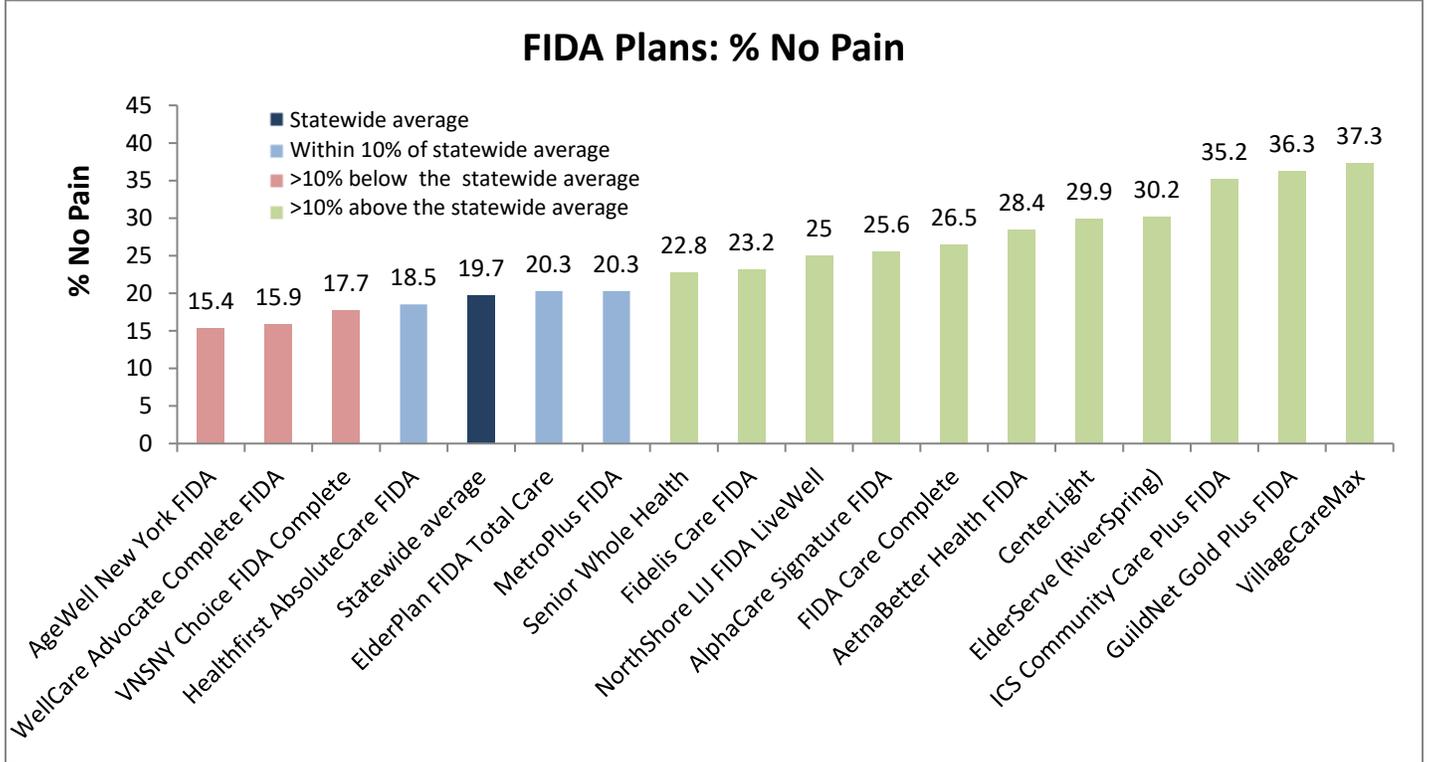


*Rate reflects data from one assessment completed.

FIDA

The percentage of members statewide that indicated **no severe daily pain** remained virtually unchanged at 19.7% in the final reporting period, compared to the initial reporting period. As illustrated in **Figure 13D**, three plans had rates for this indicator that were within 10 percent of the statewide average and two of those plans had rates that were within five percent of the statewide average. While three plans had rates that fell below the statewide average by more than 10 percent, eleven plans had rates that were greater than 10 percent above the statewide average.

Figure 13D. Percentage of FIDA members who did not experience severe or more intense pain daily.

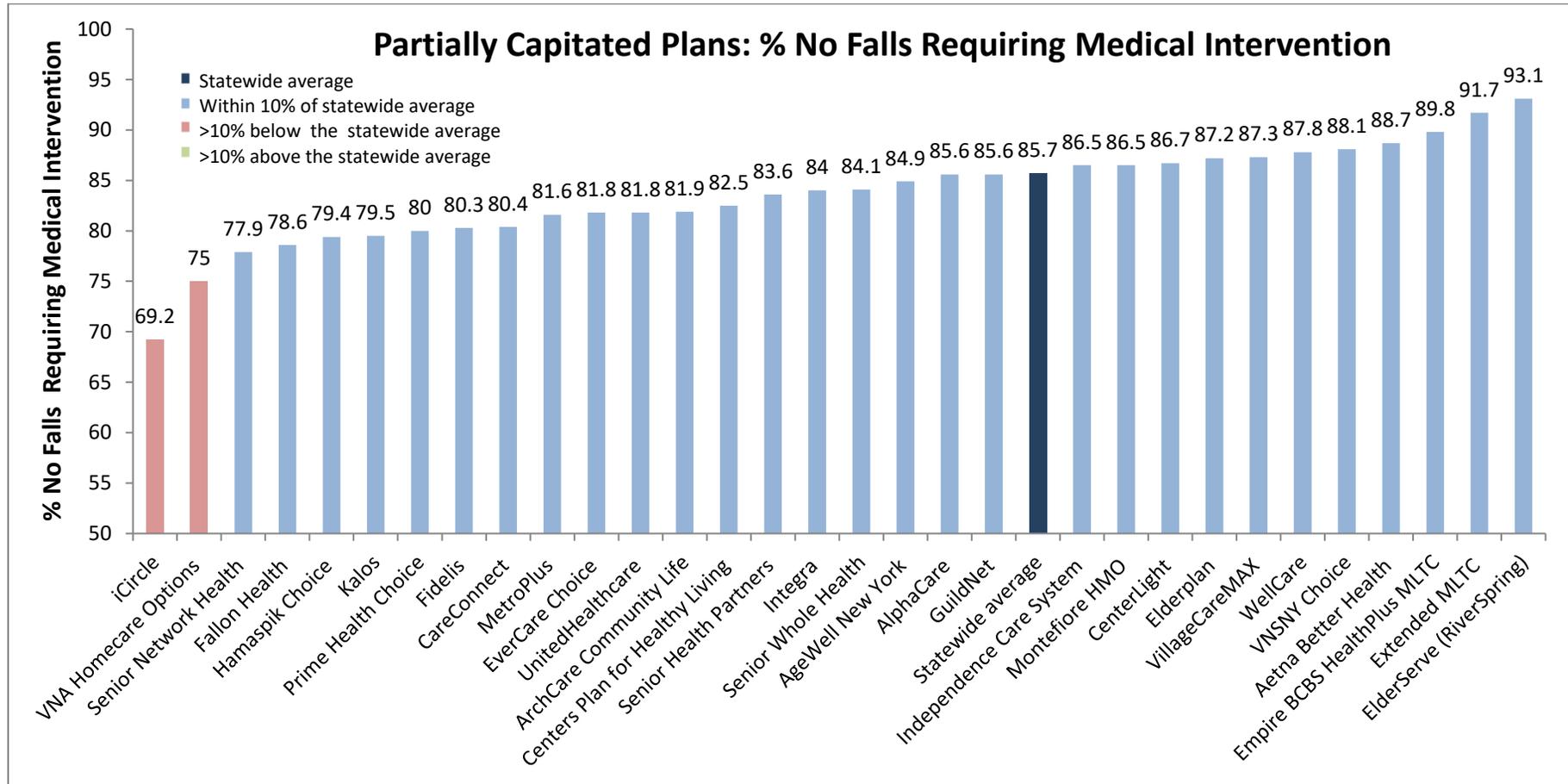


No falls requiring medical intervention in the last 90 days

Partially Capitated

Approximately the same percentage of members statewide indicated they experienced **no falls requiring medical intervention** when comparing the two reporting periods (85.6% vs. 85.7%). As shown in **Figure 14A** below, twenty-nine partially capitated plans had rates for falls that fell within 10 percent of the statewide average, and of those plans, twenty plans had rates that fell within five percent of the statewide average. The remaining two plans' rates were below the statewide average by more than 10 percent.

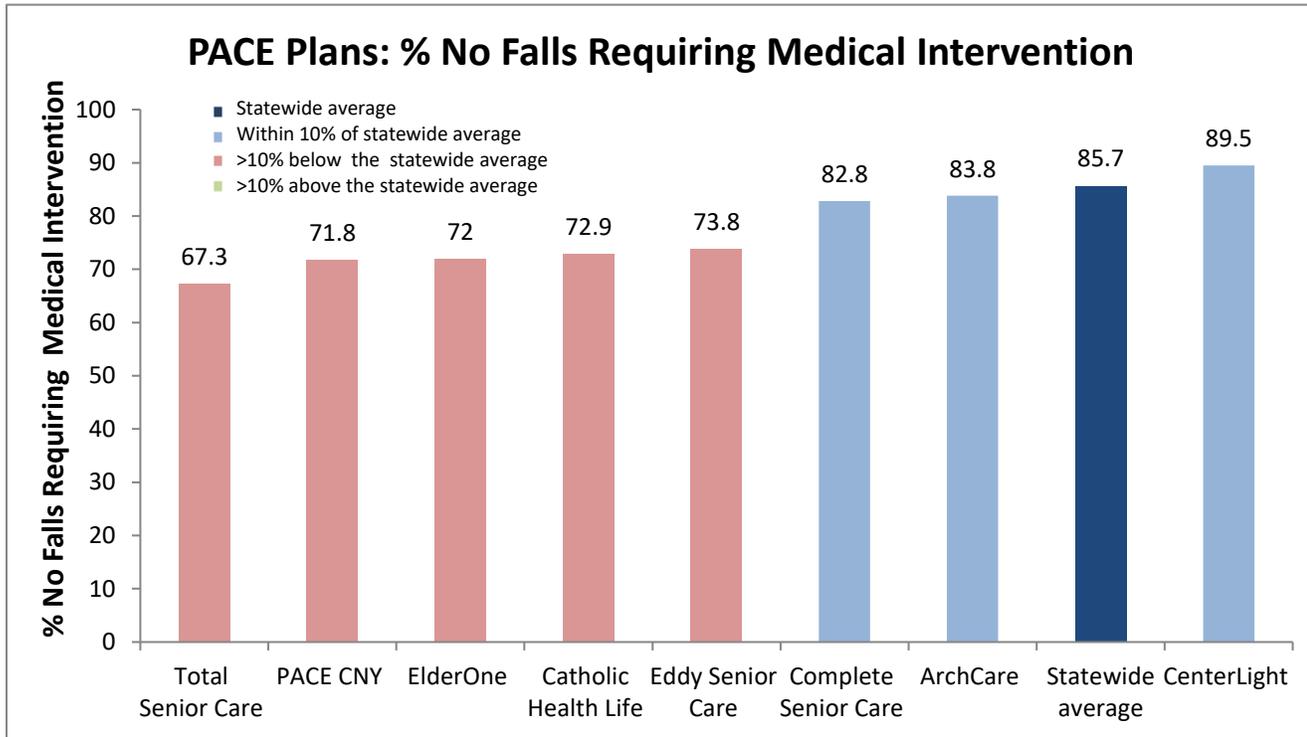
14A. Percentage of Partially Capitated members who did not have falls that required medical intervention in the last 90 days.



PACE

The statewide average for the **no falls** requiring medical intervention indicator remained unchanged at 85.7%. According to Figure 14B, three plans had rates for this indicator that were within five percent of the statewide average. Of note, five plans had rates for this indicator that were greater than 10 percent below the statewide average.

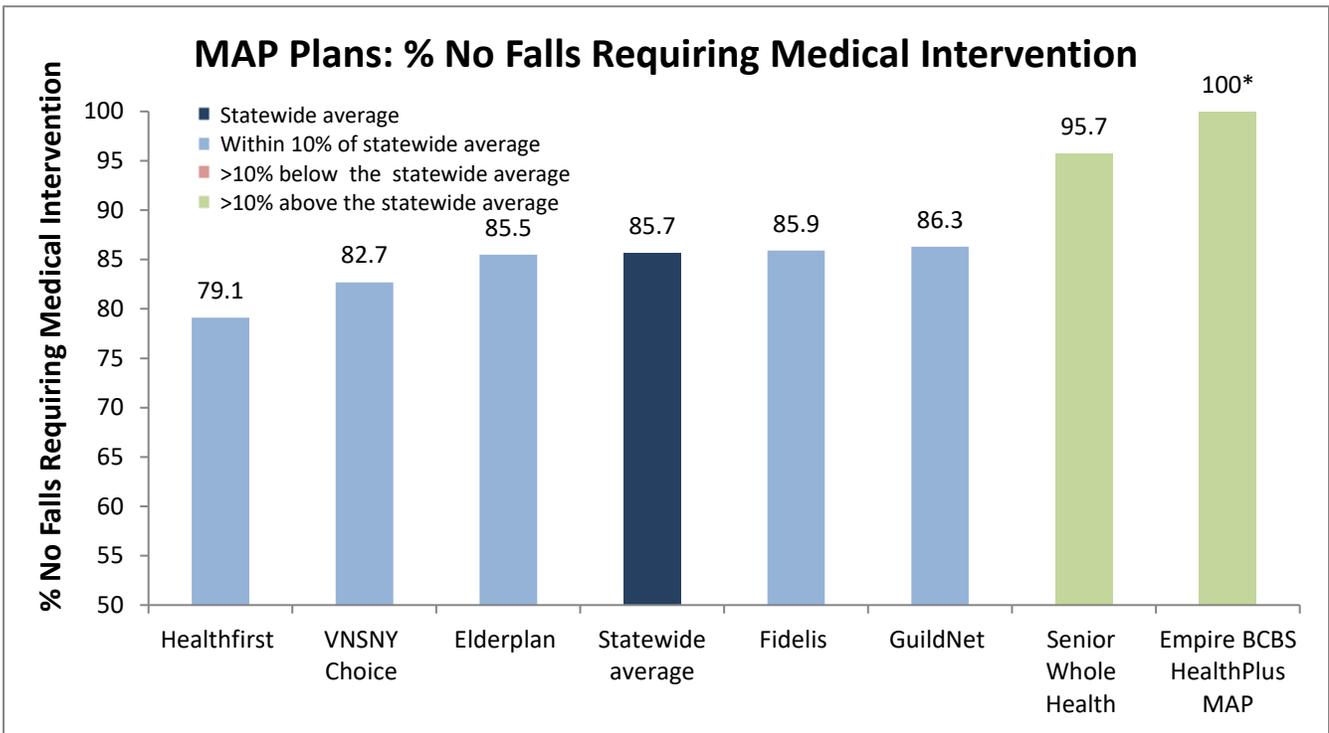
14B. Percentage of PACE members who did not have falls that required medical intervention in the last 90 days.



MAP

The percentage of members that indicated **no falls** requiring medical intervention in the last 90 days remained virtually unchanged at 85.7%. As shown in **Figure 14C**, five MAP plans had rates within 10 percent of the statewide average, and four of those plans had rates within five percent of the statewide average for this indicator. Of note, two plans had rates that were greater than 10 percent above the statewide average.

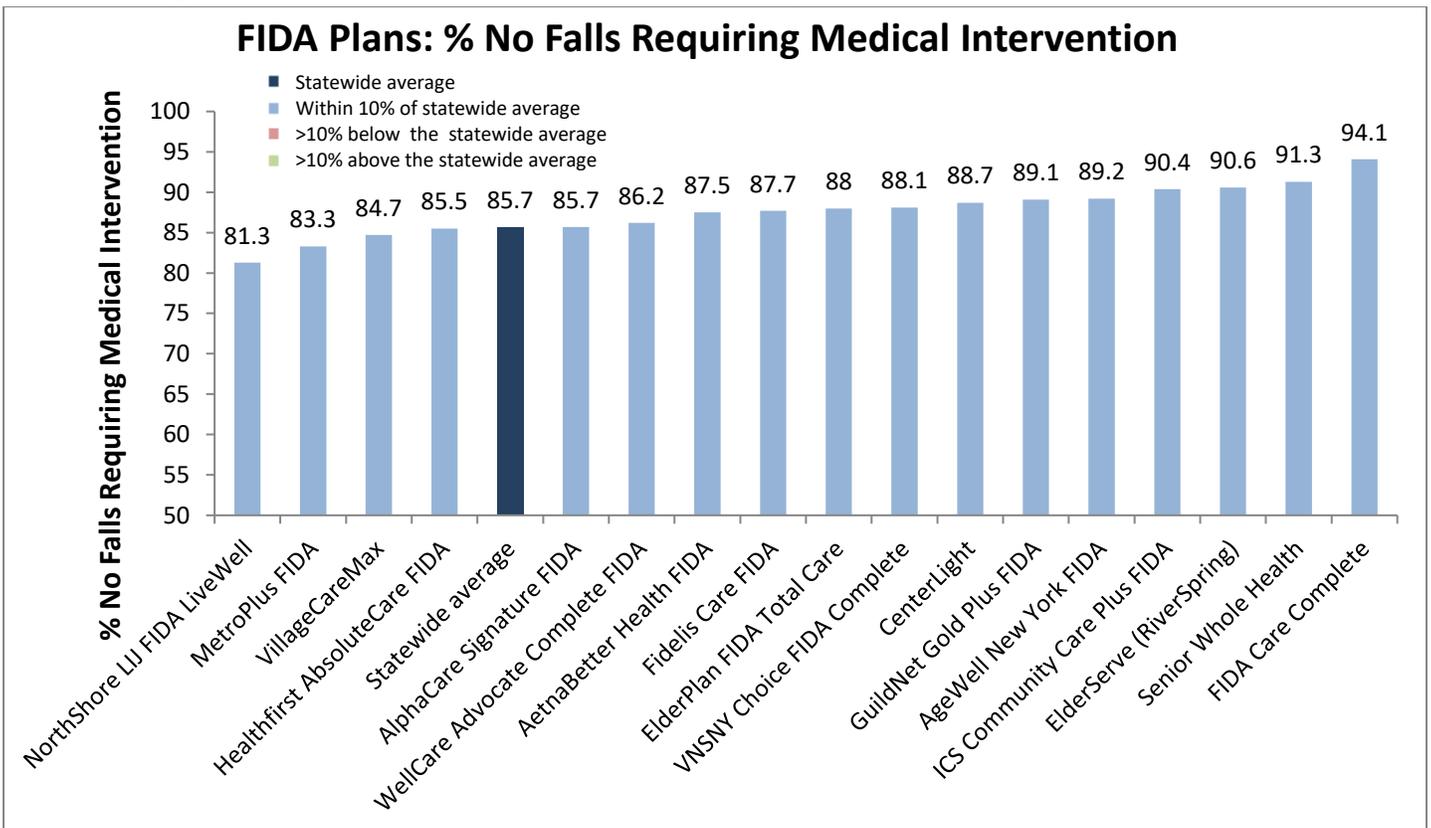
14C. Percentage of MAP members who did not have falls that required medical intervention in the last 90 days.



*Rate reflects data from one assessment completed.

FIDA
 For the **no falls** requiring medical intervention indicator, the statewide average remained virtually unchanged in the final reporting period at 85.7%. All 17 FIDA plans had rates that were within 10 percent of the statewide average, and thirteen of those plans had rates that were within five percent of the statewide average, as indicated in **Figure 14D**.

14D. Percentage of FIDA members who did not have falls that required medical intervention in the last 90 days.



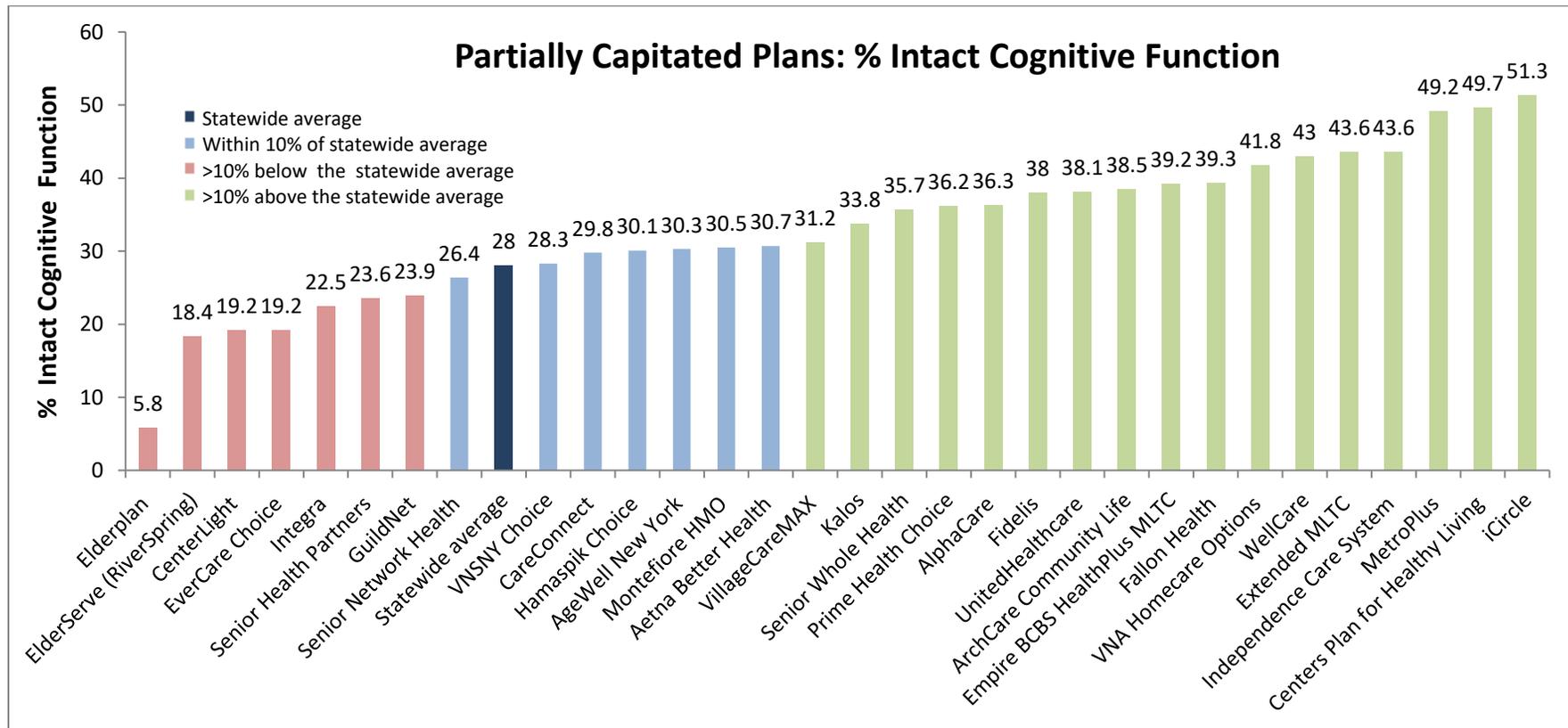
Behavioral Health Indicators

Intact Cognitive Function

Partially Capitated

The statewide average for **cognitive function** decreased two percentage points from the first reporting period (30%) to the second reporting period (28%) on the assessment. As indicated by **Figure 15A** below, seven partially capitated plans had rates for this indicator that were within 10 percent of the statewide average, of which two plans were within five percent of the statewide average. Of note, seventeen plans had rates that exceeded the statewide average by more than 10 percent. Conversely, seven plans had rates for cognitive function that were below the statewide average by more than 10 percent.

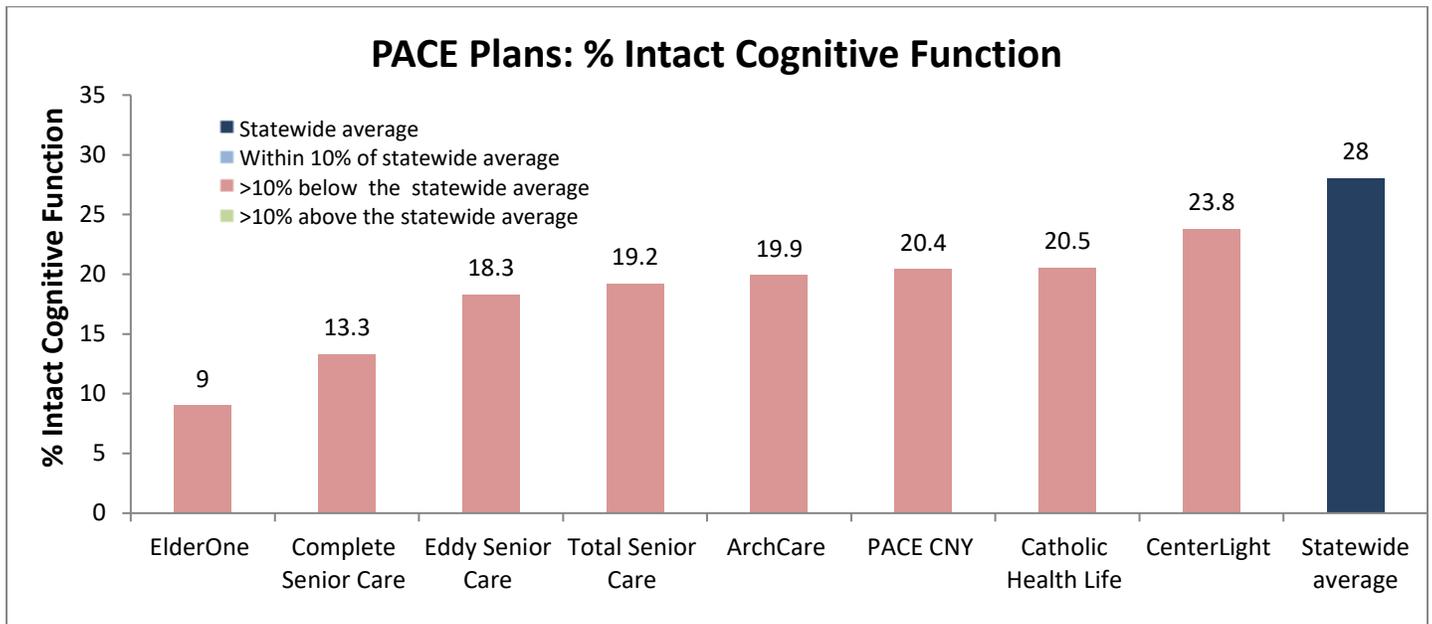
Figure 15A. Percentage of Partially Capitated members whose Cognitive Performance Scale (CPS) indicated intact functioning.



PACE

The statewide average for the percentage of members indicating that they had **intact cognitive functioning** decreased two percentage points to 28% in July-December 2015. As shown in **Figure 15B**, all of the eight PACE plans had rates for this indicator that fell greater than 10 percent below the statewide average.

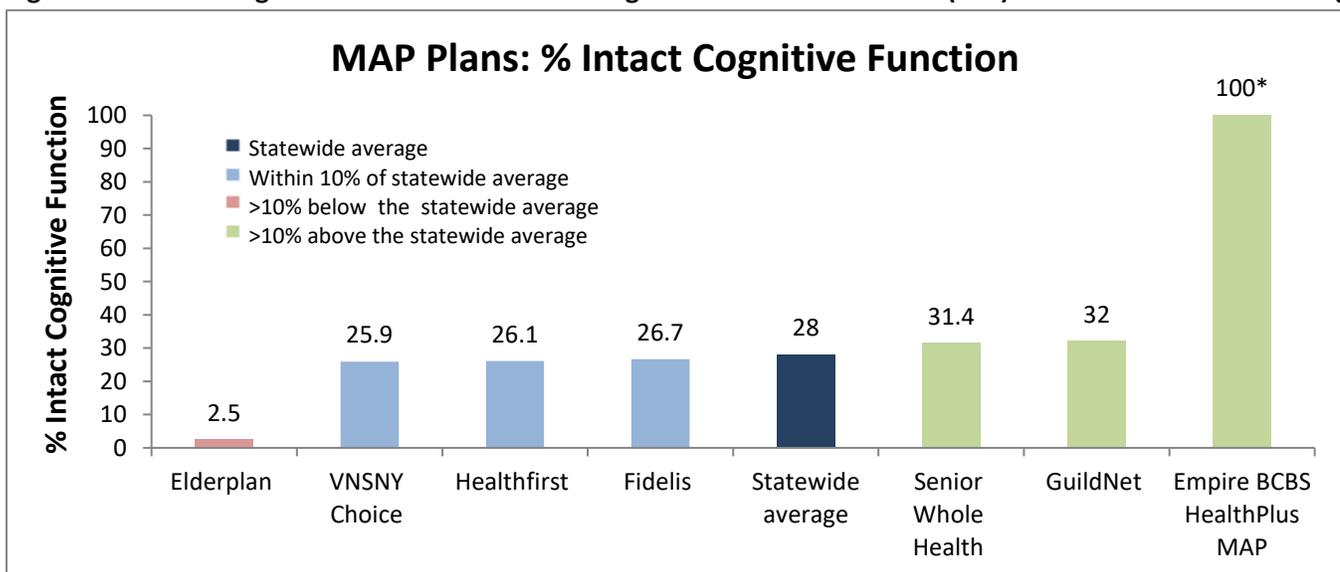
Figure 15B. Percentage of PACE members whose Cognitive Performance Scale (CPS) indicated intact functioning.



MAP

The percentage of members statewide that indicated having **intact cognitive functioning** decreased by two percentage points from 30% in the initial reporting period to 28% in the final reporting period. Three MAP plans had rates for this indicator that were within 10 percent of the statewide average in the final reporting period, as indicated by **Figure 15C**. One of those plans had a rate for behavioral health that was within five percent of the statewide average. While one plan’s rate was below the statewide average by more than 10 percent, three MAP plans had rates that exceeded the statewide average by more than 10 percent.

Figure 15C. Percentage of MAP members whose Cognitive Performance Scale (CPS) indicated intact functioning.

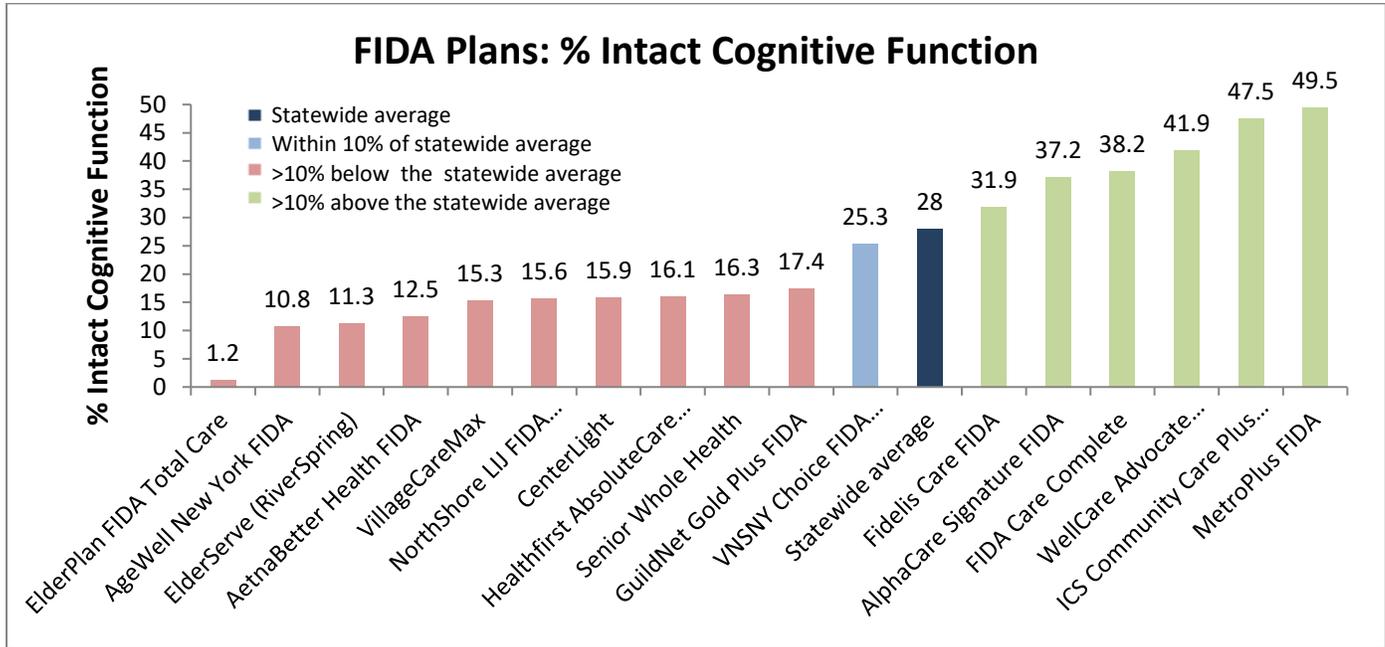


*Rate reflects data from one assessment completed.

FIDA

The statewide average for **cognitive function** decreased two percentage points from 30% in the initial reporting period, to 28% in the final reporting period. As seen in **Figure 15D**, there was one FIDA plan whose rate was within 10 percent of the statewide average. While there were 10 plans that had rates for this indicator that were greater than 10 percent below the statewide average, six plans had rates that exceeded the statewide average by more than 10 percent.

Figure 15D. Percentage of FIDA members whose Cognitive Performance Scale (CPS) indicated intact functioning.

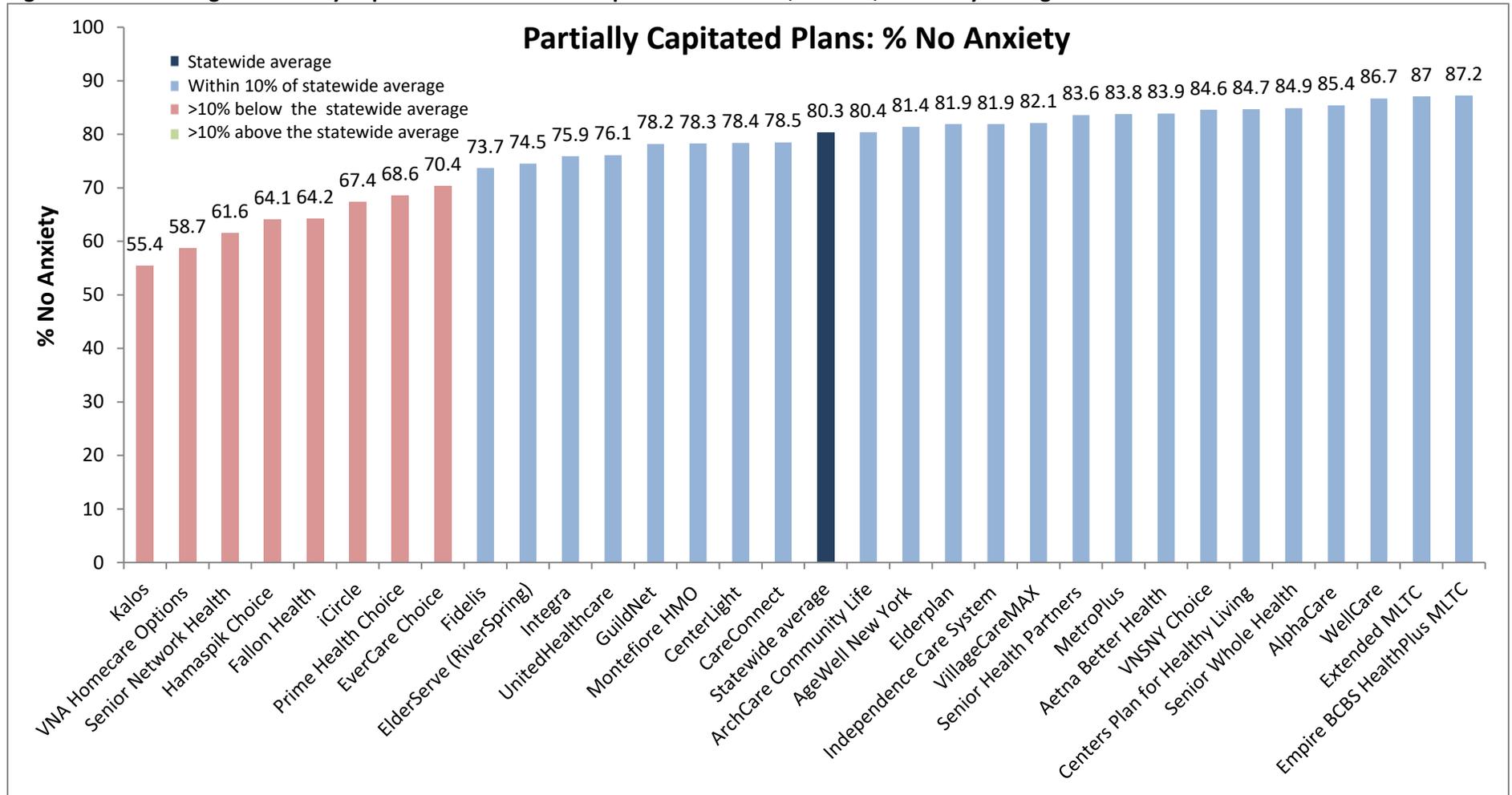


No Anxiety

Partially Capitated

The average percentage of members statewide who experienced **no anxious, restless, or uneasy feelings** decreased by one percentage point to 80.3% in the second reporting period. **Figure 16A** demonstrates that there were twenty-three plans that had rates within 10 percent of the statewide average and twelve of those plans had rates within five percent of the statewide average. Of note, eight plans had rates for this indicator that were greater than 10 percent below the statewide average.

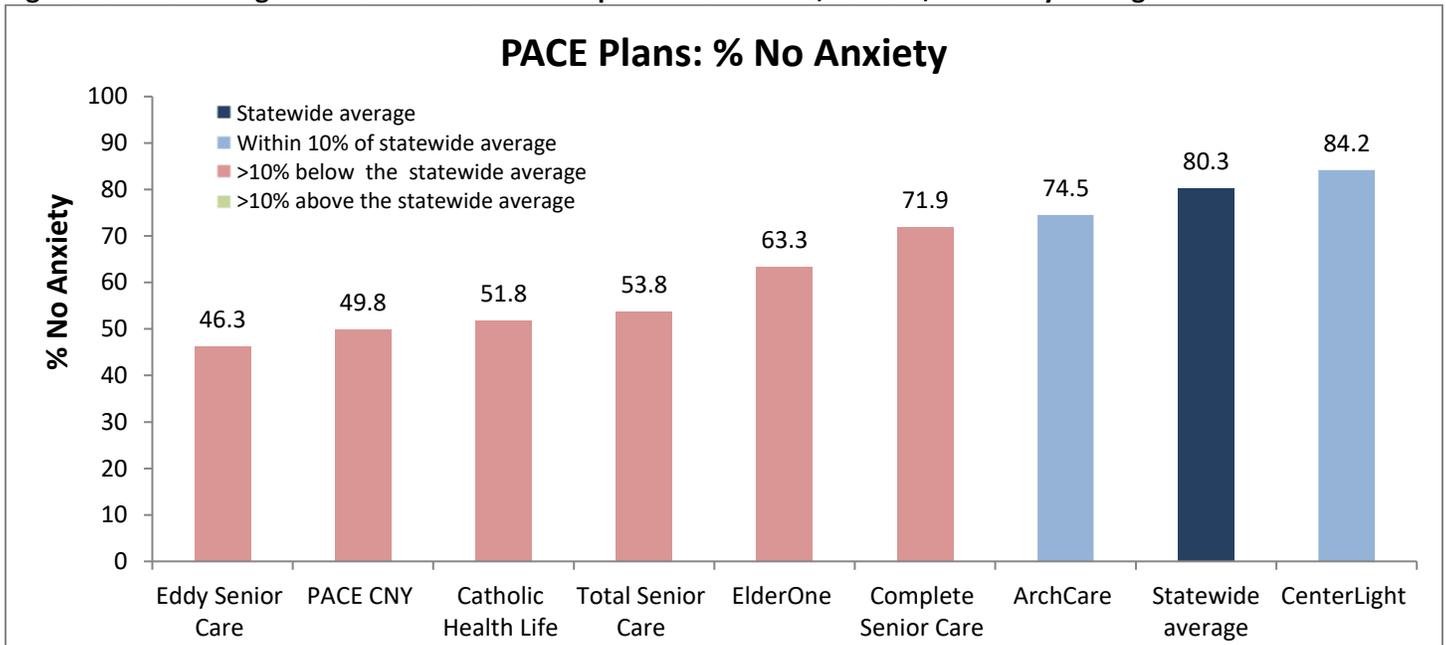
Figure 16A. Percentage of Partially Capitated members who reported no anxious, restless, or uneasy feelings.



PACE

The percentage of members statewide indicating that they had **no anxious feelings** decreased one percentage point to 80.3%. As shown in **Figure 16B**, two PACE plans had rates for this indicator that were within 10 percent of the statewide average. Of note, six plans had rates that were more than 10 percent below the statewide average.

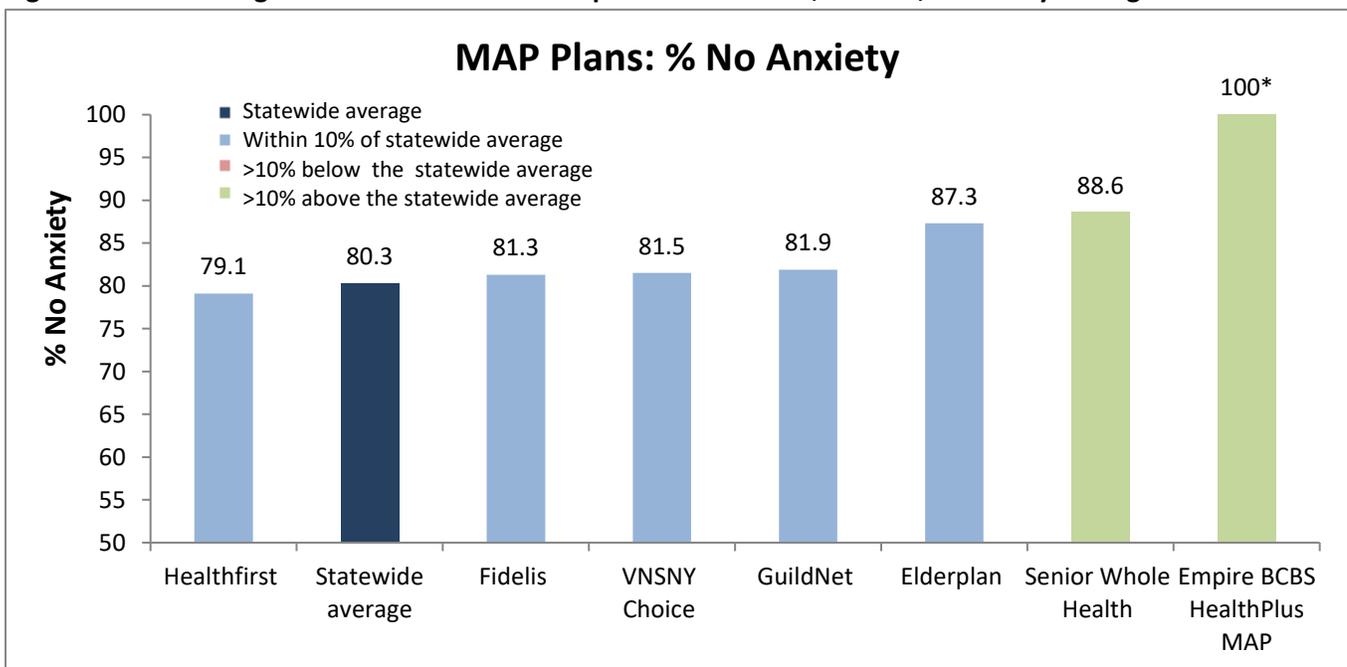
Figure 16B. Percentage of PACE members who reported no anxious, restless, or uneasy feelings.



MAP

The statewide average for **anxiety** decreased one percentage point to 80.3% in the final reporting period. As demonstrated by **Figure 16C**, there were five MAP plans that had rates for this indicator that were within 10 percent of the statewide average, and four of those plans had rates within five percent of the statewide average. Of note, two plans had rates for anxiety that exceeded the statewide average by more than 10 percent.

Figure 16C. Percentage of MAP members who reported no anxious, restless, or uneasy feelings.

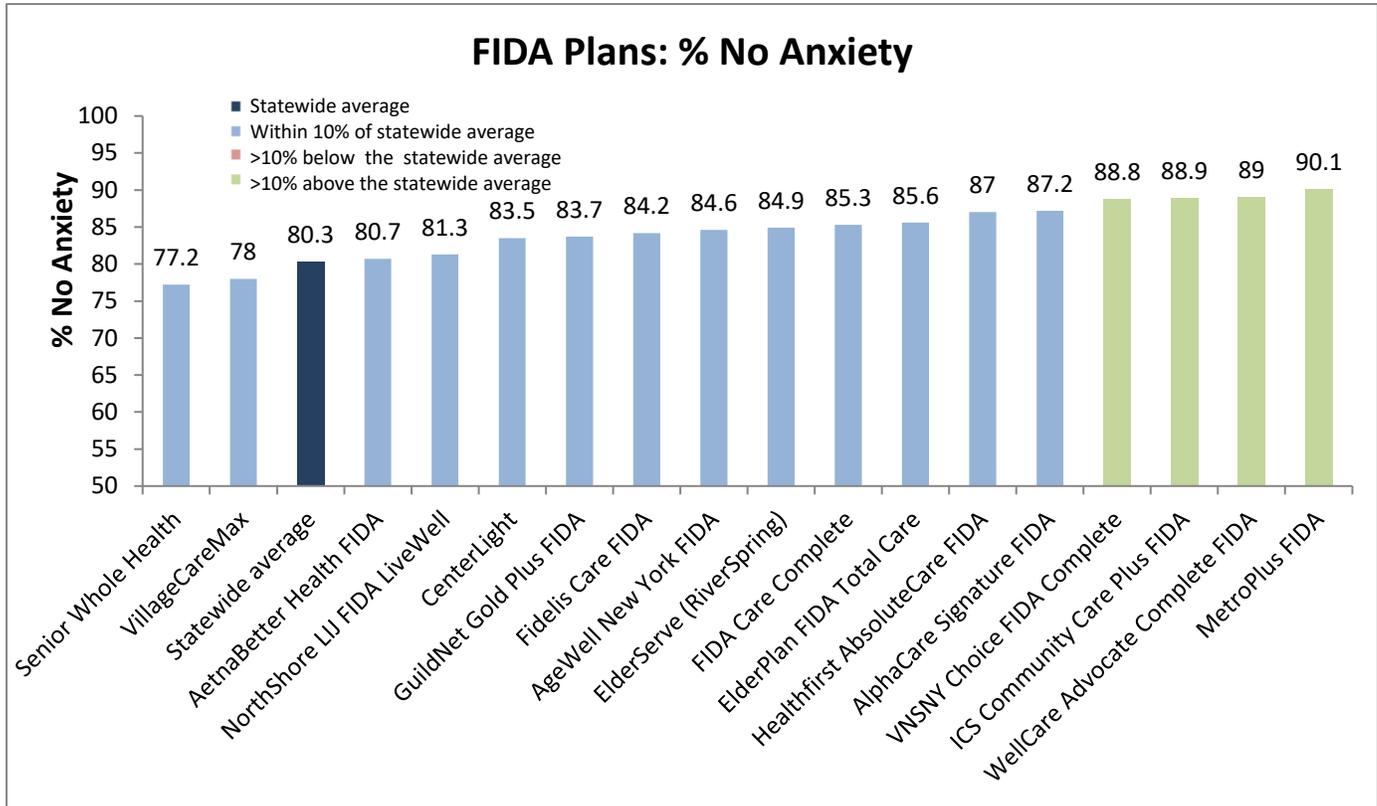


*Rate reflects data from one assessment completed.

FIDA

The statewide average for the **anxiety** indicator decreased one percentage point to 80.3% in the final reporting period. **Figure 16D** below shows that thirteen FIDA plans had rates for this indicator that were within 10 percent of the statewide average. Of those plans, seven plans had rates within five percent of the statewide average. Four plans had rates that were greater than 10 percent above the statewide average.

Figure 16D. Percentage of FIDA members who reported no anxious, restless, or uneasy feelings.

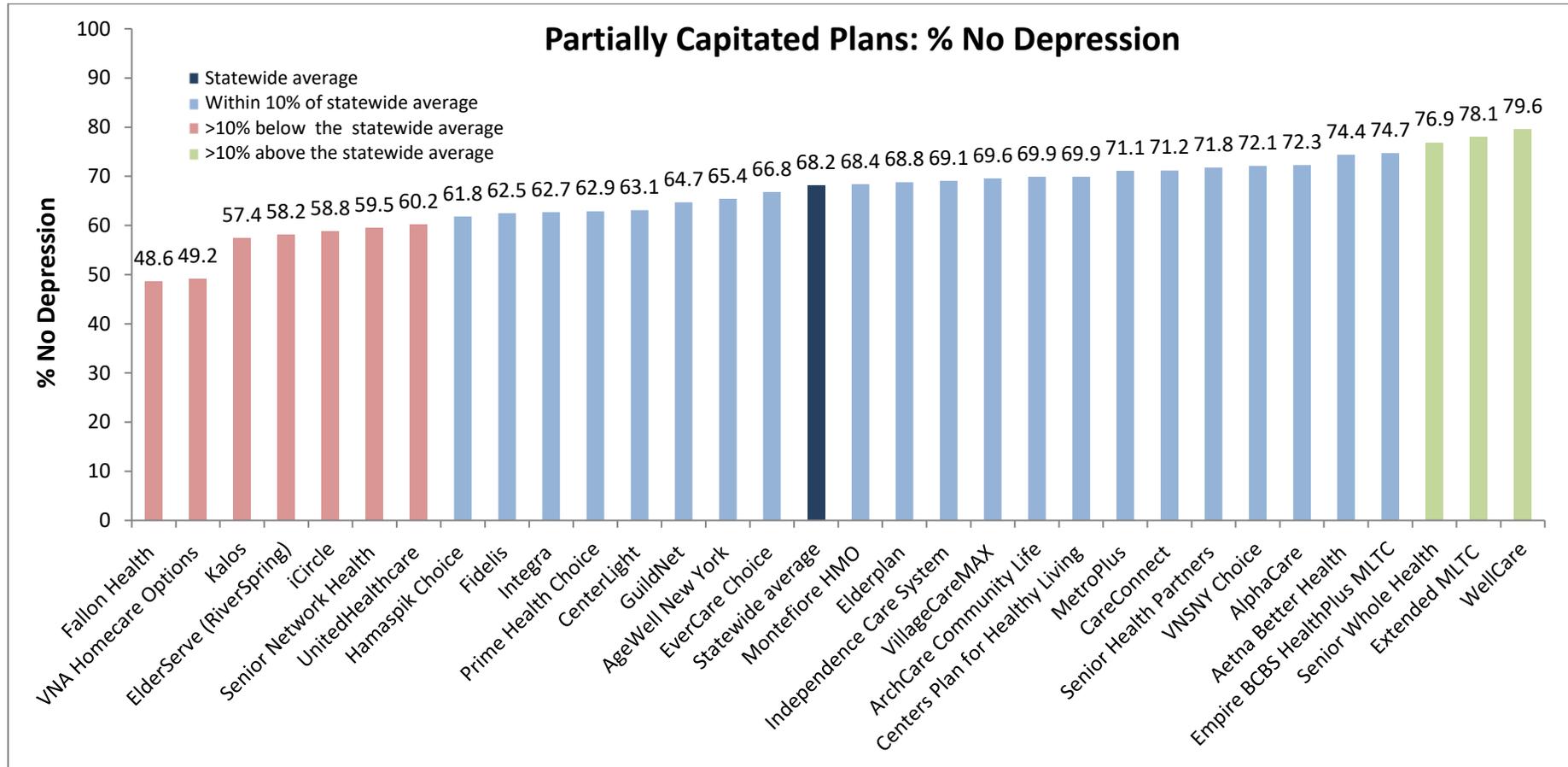


No Depression

Partially Capitated

The statewide average for **depression** decreased one percentage point to 68.2%. As indicated in **Figure 17A**, there were twenty-one partially capitated plans whose rates for this indicator were within 10 percent of the statewide average; ten of those plans had rates within five percent of the statewide average. While seven plans had rates for depression that were below the statewide average by more than 10 percent, three plans had rates which exceeded the statewide average by more than 10 percent.

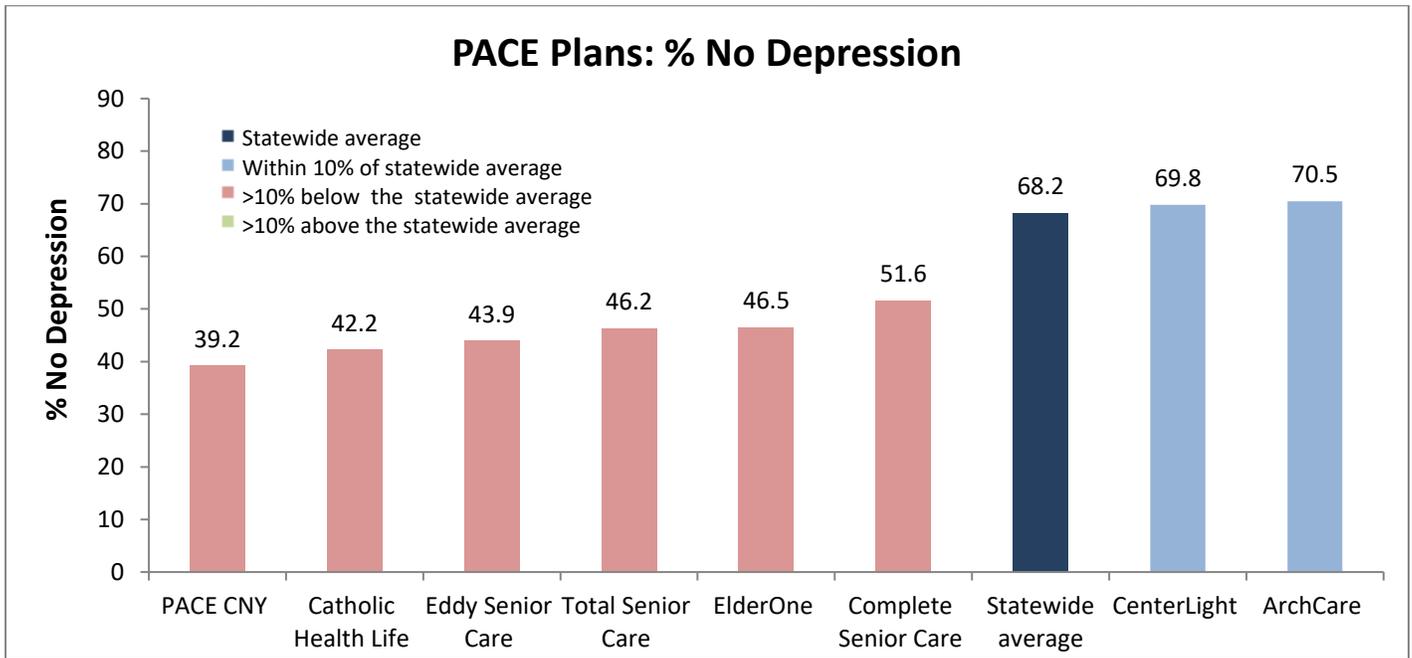
Figure 17A. Percentage of Partially Capitated members who reported no sad, depressed, or hopeless feelings.



PACE

For **depression**, the statewide average decreased by one percentage point to 68.2% in July-December 2015. As shown in **Figure 17B** below, two PACE plans had rates for depression that were within 10 percent of the statewide average. There were six plans which had rates that were below the statewide average by more than 10 percent.

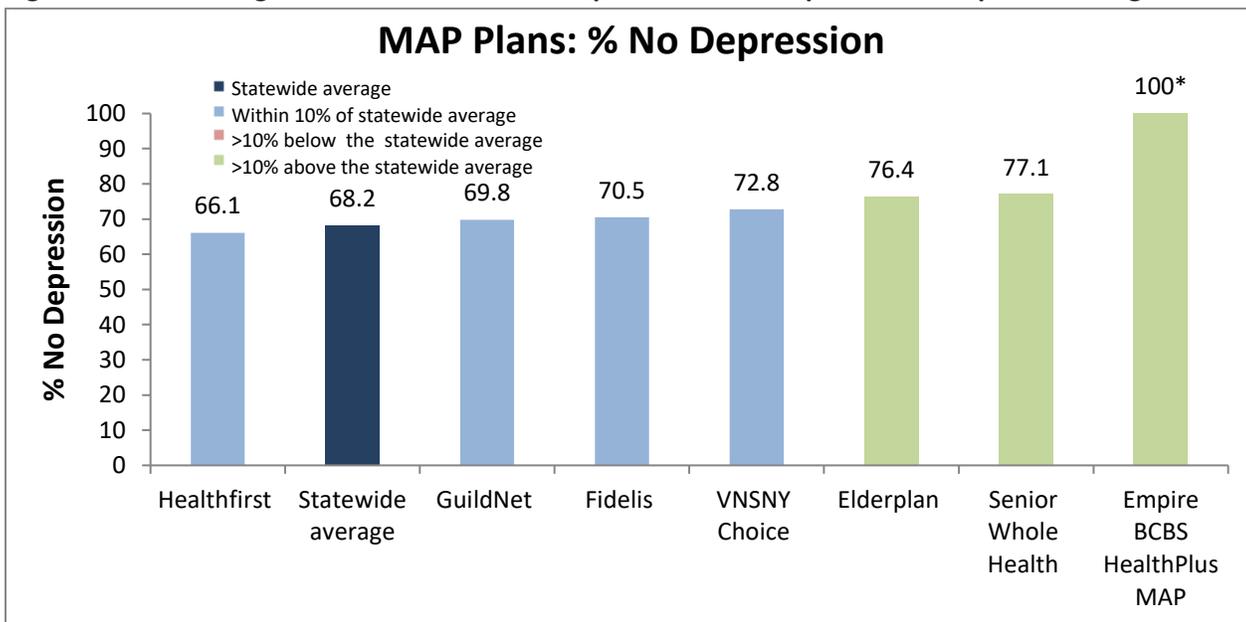
Figure 17B. Percentage of PACE members who reported no sad, depressed, or hopeless feelings.



MAP

The statewide average for **depression** decreased one percentage point to 68.2% in the final reporting period. As indicated by **Figure 17C** below, four MAP plans had rates for this indicator that were within 10 percent of the statewide average and three of those plans had rates within five percent of the statewide average. There were three plans whose rates for depression were greater than 10 percent above the statewide average.

Figure 17C. Percentage of MAP members who reported no sad, depressed, or hopeless feelings.

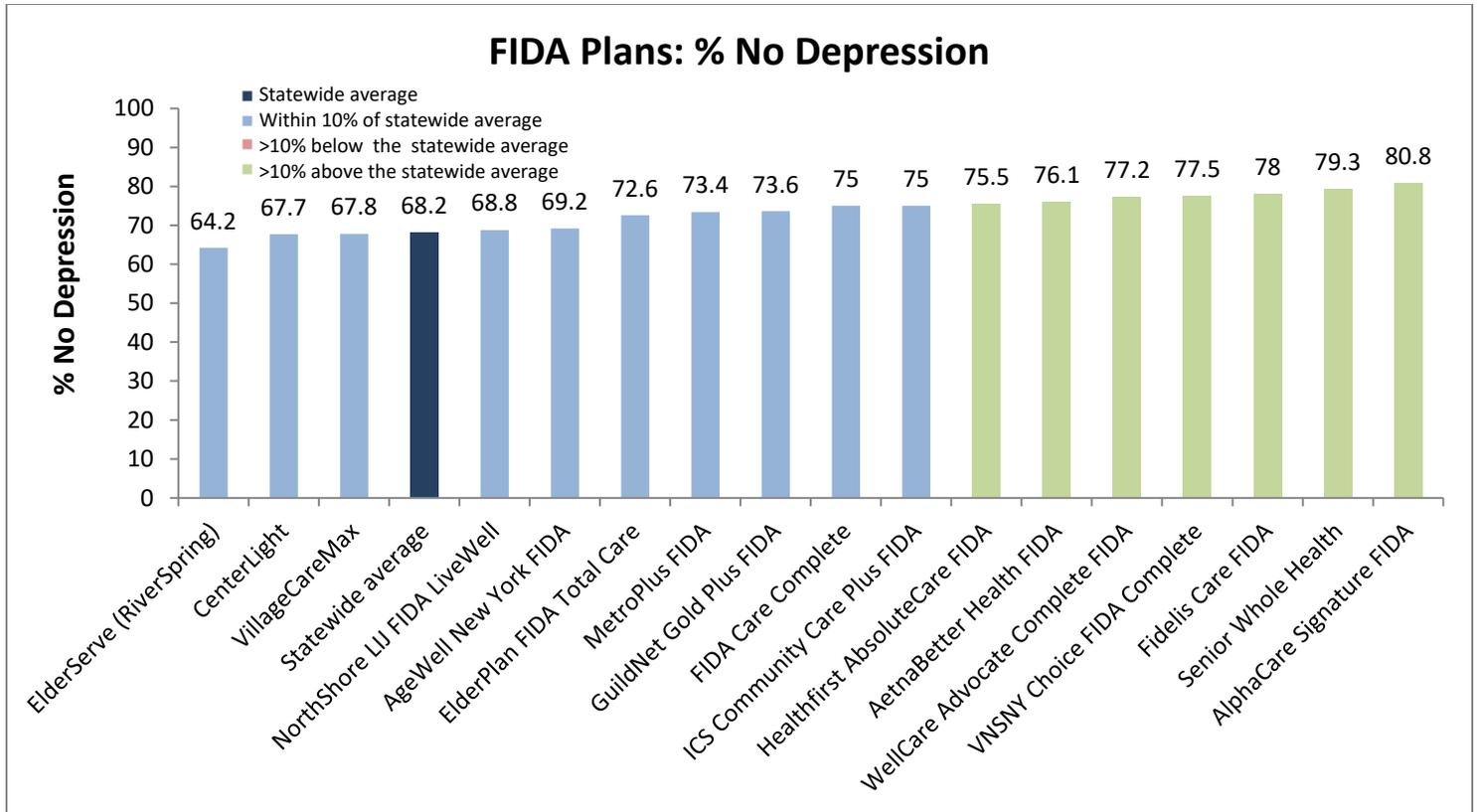


*Rate reflects data from one assessment completed.

FIDA

For **depression**, the statewide average decreased by one percentage point from 69.2% to 68.2%. **Figure 17D** illustrates that ten FIDA plans had rates for this indicator that were within 10 percent of the statewide average and four of those plans had rates that were within five percent of the statewide average. The remaining seven FIDA plans had rates that exceeded the statewide average by more than 10 percent.

Figure 17D. Percentage of FIDA members who reported no sad, depressed, or hopeless feelings.



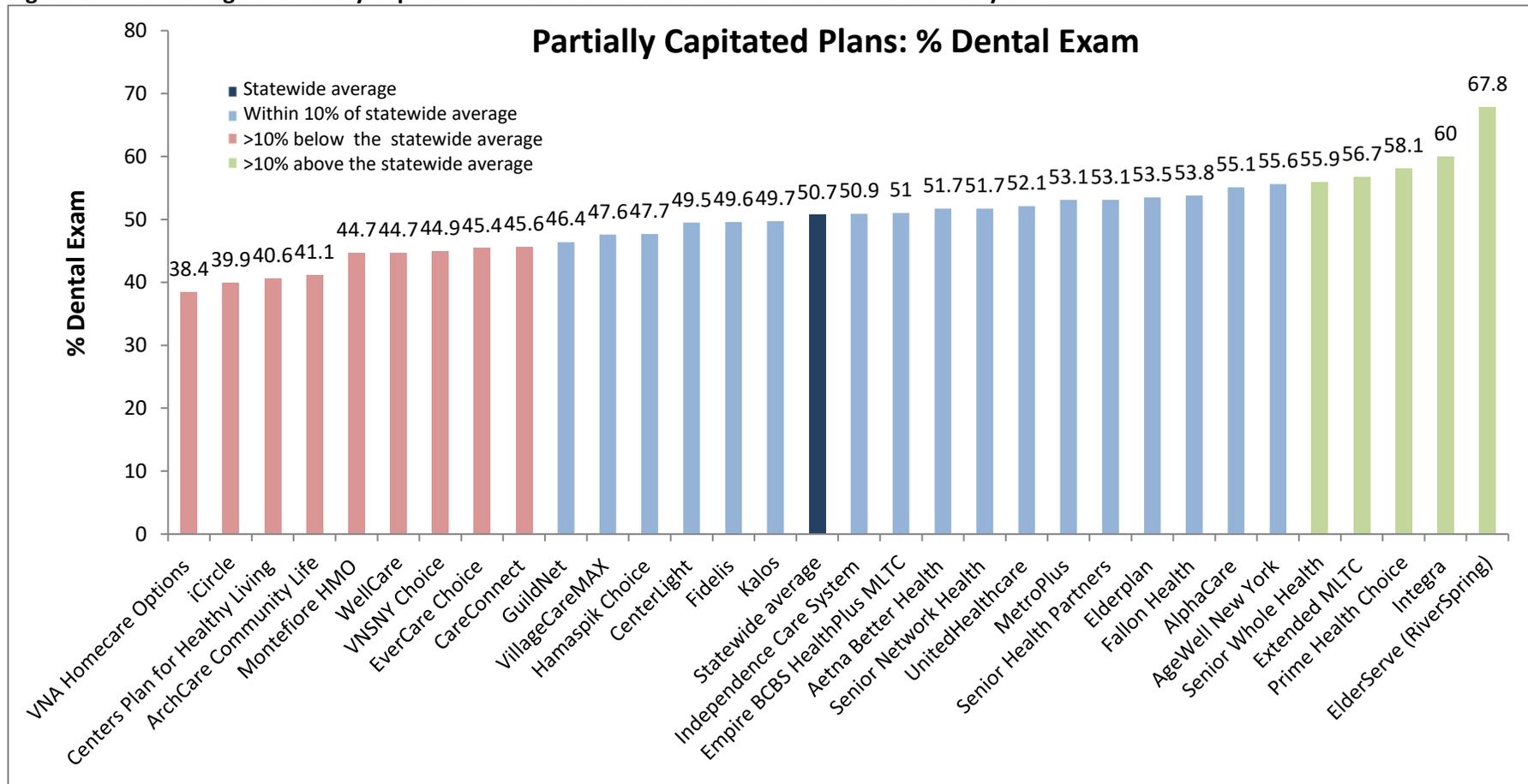
Preventive Screening Indicators

Dental Exams

Partially Capitated

The statewide average for the **dental screenings** increased slightly by one percentage point to 50.7% in the July-December 2015 reporting period. **Figure 18A** demonstrates that seventeen partially capitated plans had rates for this indicator that were within 10 percent of the statewide average and ten of those plans had rates for this indicator that were within five percent of the statewide average. There were five plans that had rates that were greater than 10 percent above the statewide average. Conversely, there were nine plans that had rates for dental screening that were greater than 10 percent below the statewide average.

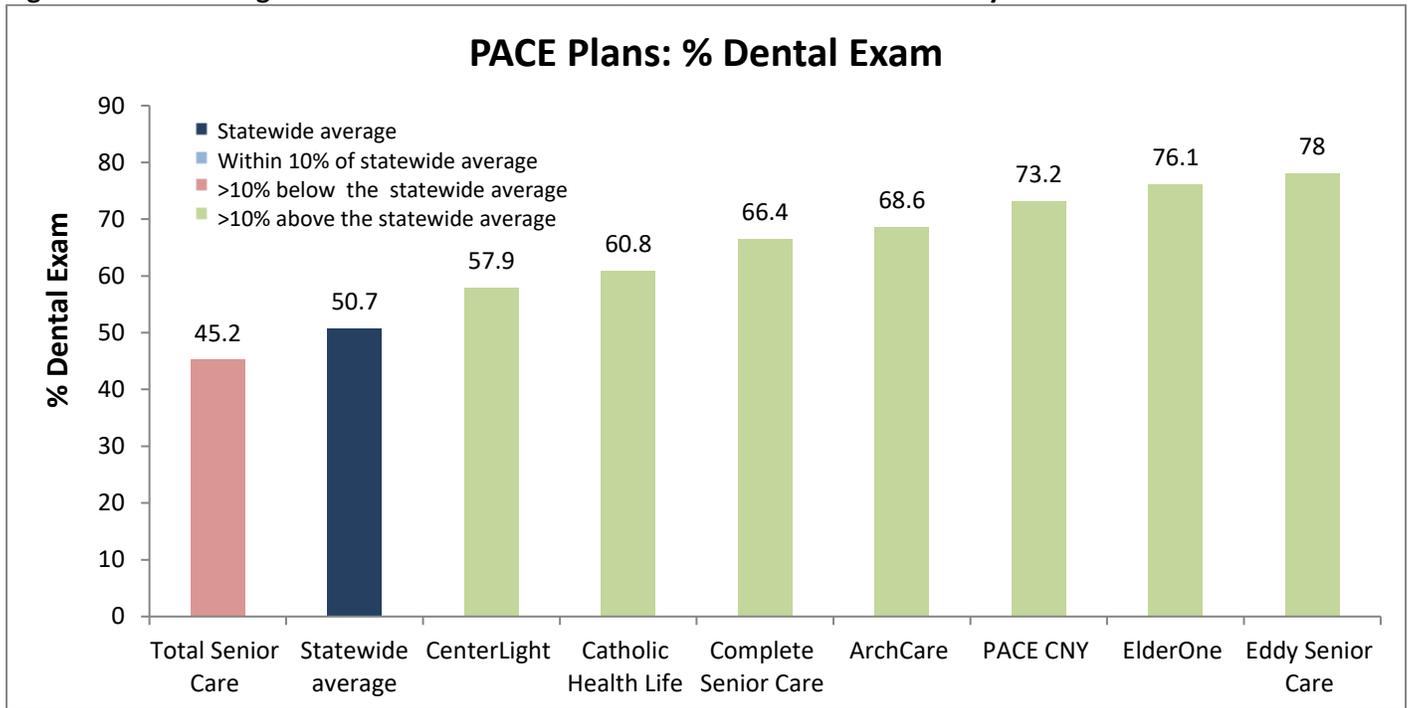
Figure 18A. Percentage of Partially Capitated members who received a dental exam in the last year.



PACE

The statewide average for **dental exams** increased one percentage point to 50.7% in the July-December 2015 reporting period. As shown in **Figure 18B** below, seven PACE plans had rates that exceeded the statewide average by more than 10 percent and one plan’s rate was more than 10 percent below the statewide average.

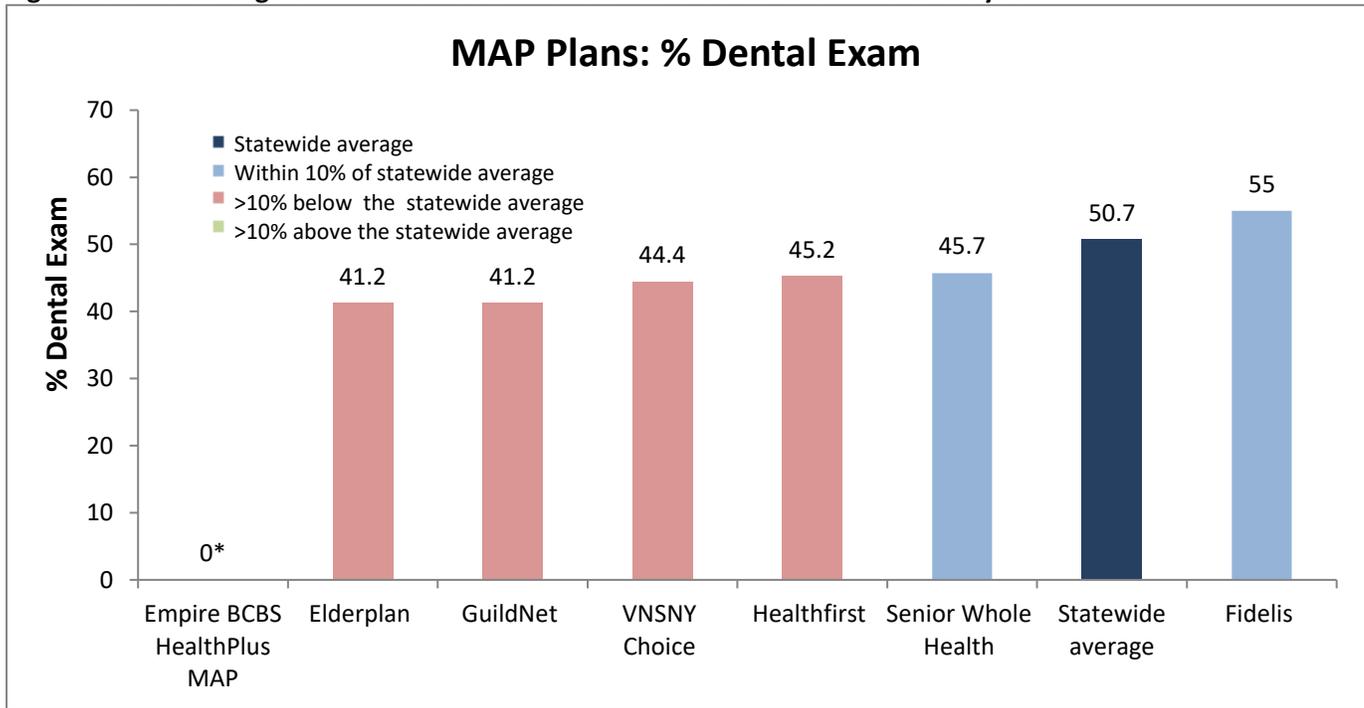
Figure 18B. Percentage of PACE members who received a dental exam in the last year.



MAP

The percentage of members statewide who indicated having a **dental exam** in the last year decreased one percentage point to 50.7%. **Figure 18C** demonstrates that two MAP plans had rates within 10 percent of the statewide average. Of note, there were five plans whose rates were more than 10 percent below the statewide average.

Figure 18C. Percentage of MAP members who received a dental exam in the last year.

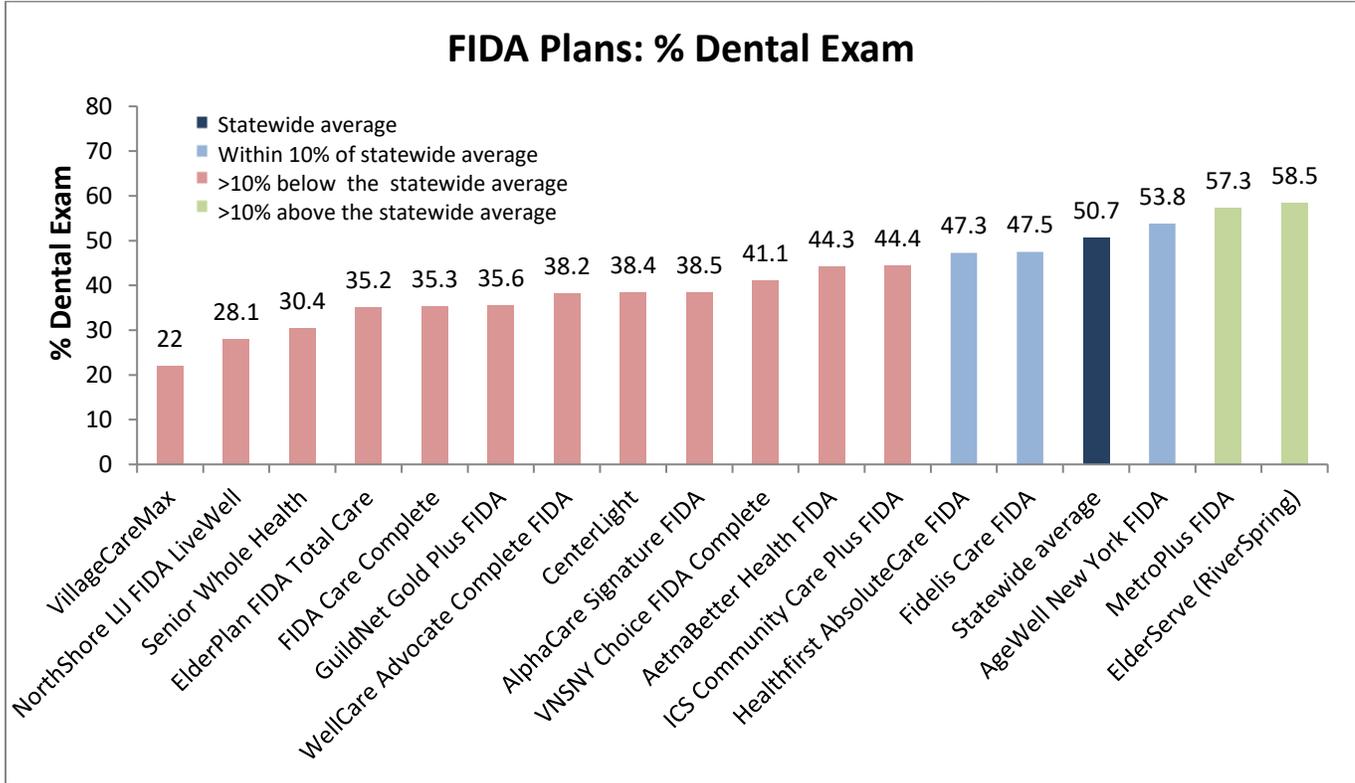


*Rate reflects data from one assessment completed.

FIDA

The percentage of members statewide who indicated they had a **dental exam** in the last year increased by one percentage point from 49.7% to 50.7%. As shown in **Figure 18D** below, three FIDA plans had rates for this indicator that were within 10 percent of the statewide average. There were two plans whose rates for this indicator were greater than 10 percent above the statewide average and twelve plans whose rates for this indicator were greater than 10 percent below the statewide average.

Figure 18D. Percentage of FIDA members who received a dental exam in the last year.

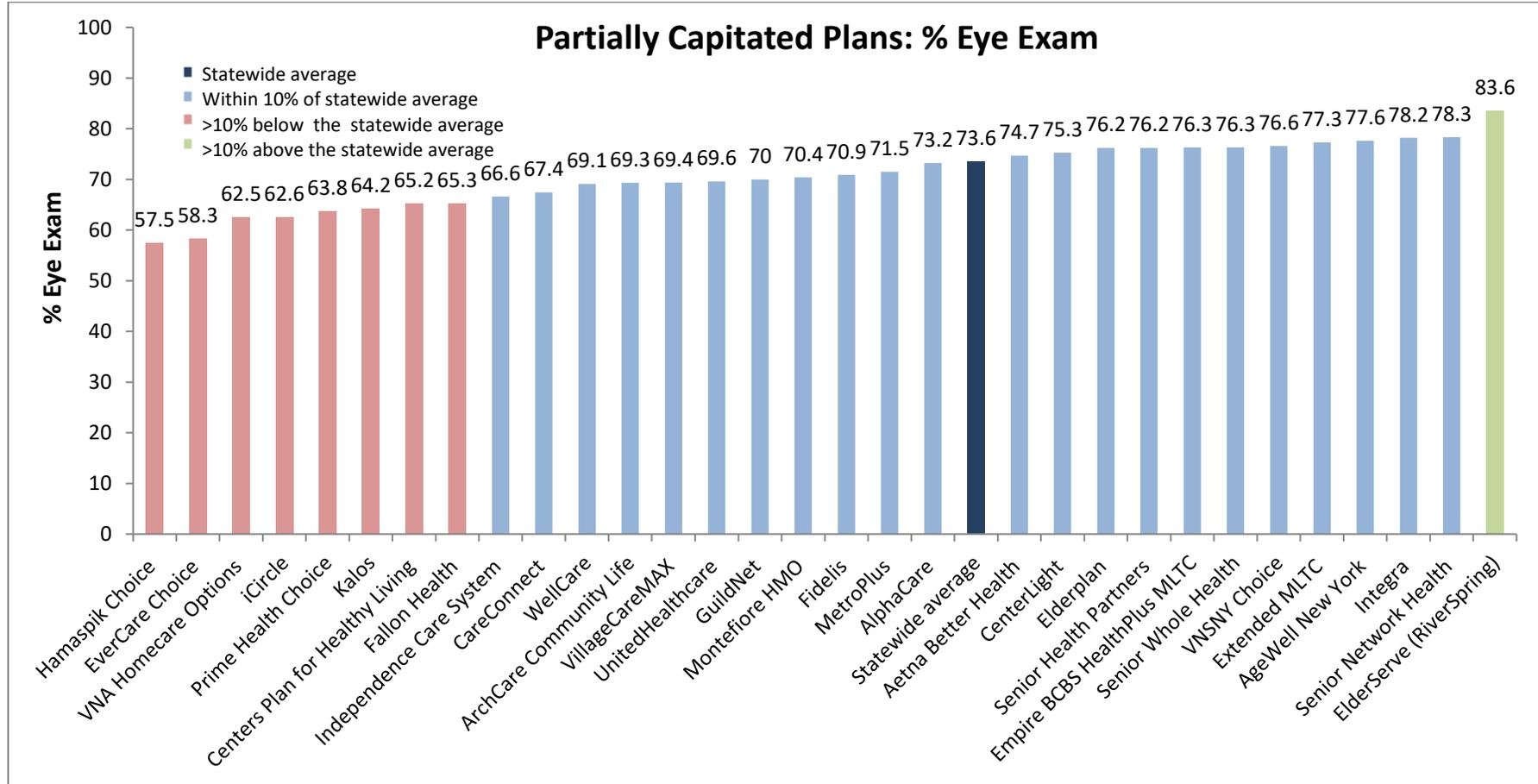


Eye Exams

Partially Capitated

The indicator for **eye exams** remained virtually unchanged between the two reporting periods (73.1% vs. 73.6%). As shown in **Figure 19A** below, twenty-two plans had rates for eye exams that were within 10 percent of the statewide average and 12 of those plans had rates that were within five percent of the statewide average. While eight plans had rates that fell below the statewide average by more than 10 percent, one plan's rate exceeded the statewide average by more than 10 percent.

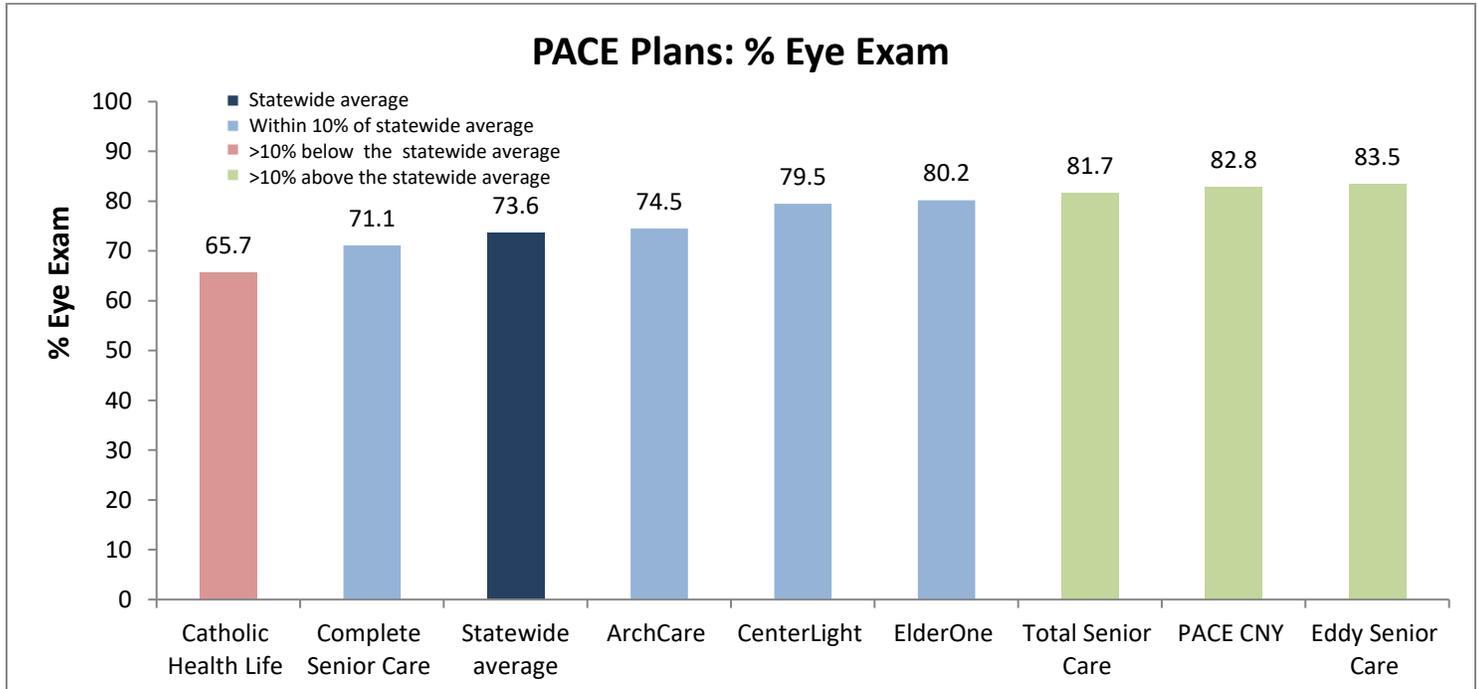
Figure 19A. Percentage of Partially Capitated members who received an eye exam in the last year.



PACE

For **eye exams**, the statewide average increased slightly by 0.5 percentage points to 73.6% in the second reporting period. As shown in **Figure 19B** below, of the eight PACE plans, four plans had rates for eye exams that were within 10 percent of the statewide average, of which two plans had rates that were within five percent of the statewide average. While three plans had rates that exceeded the statewide average by more than 10 percent, one plan's rate fell below the statewide average by more than 10 percent.

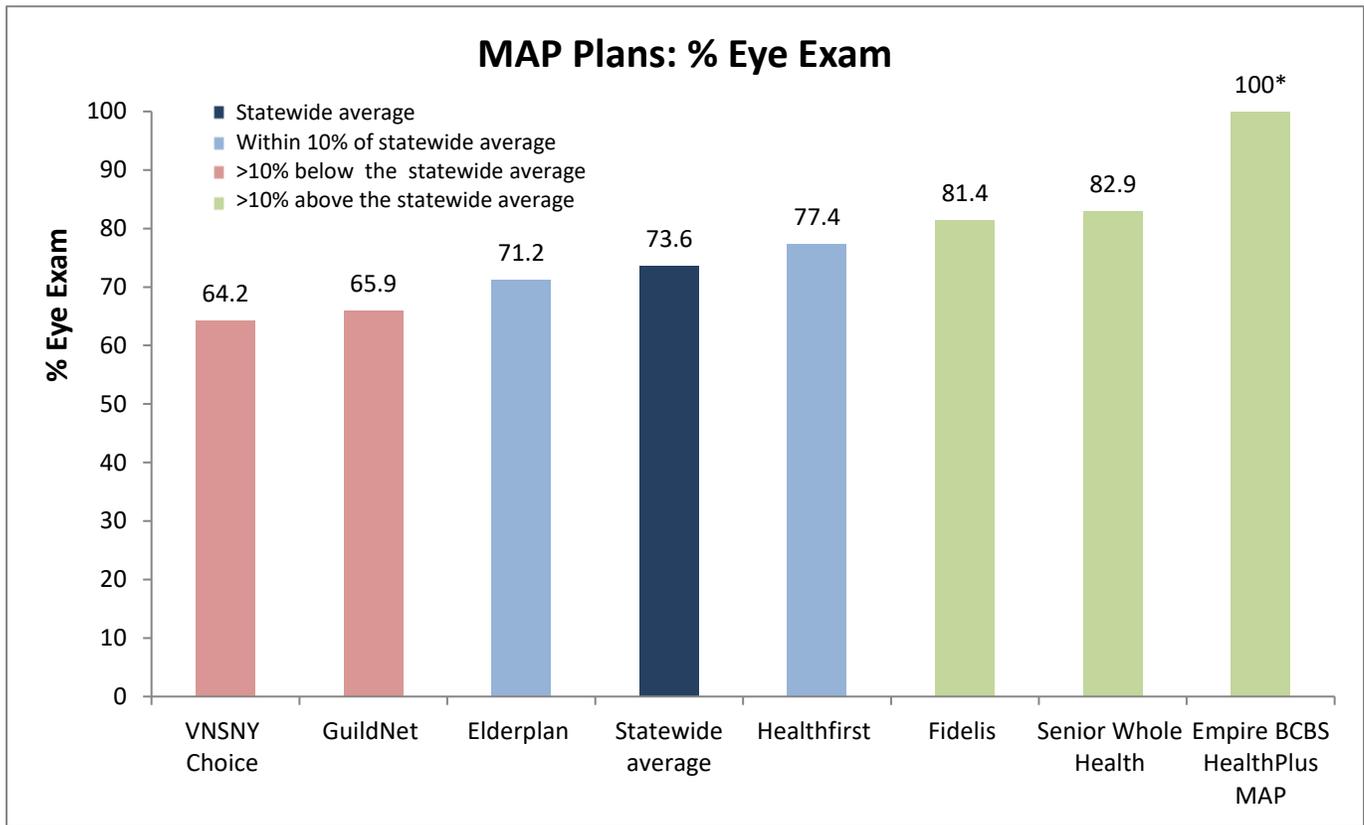
Figure 19B. Percentage of PACE members who received an eye exam in the last year.



MAP

For **eye exams**, the statewide average increased slightly from 73.1% in the initial reporting period to 73.6% in the final reporting period. **Figure 19C** demonstrates that two MAP plans had rates within 10 percent of the statewide average, one of which whose rate fell within five percent of the statewide average. While two plans had rates that were below the statewide average by more than 10 percent, three plans had rates for eye exams that were greater than 10 percent above the statewide average.

Figure 19C. Percentage of MAP members who received an eye exam in the last year.

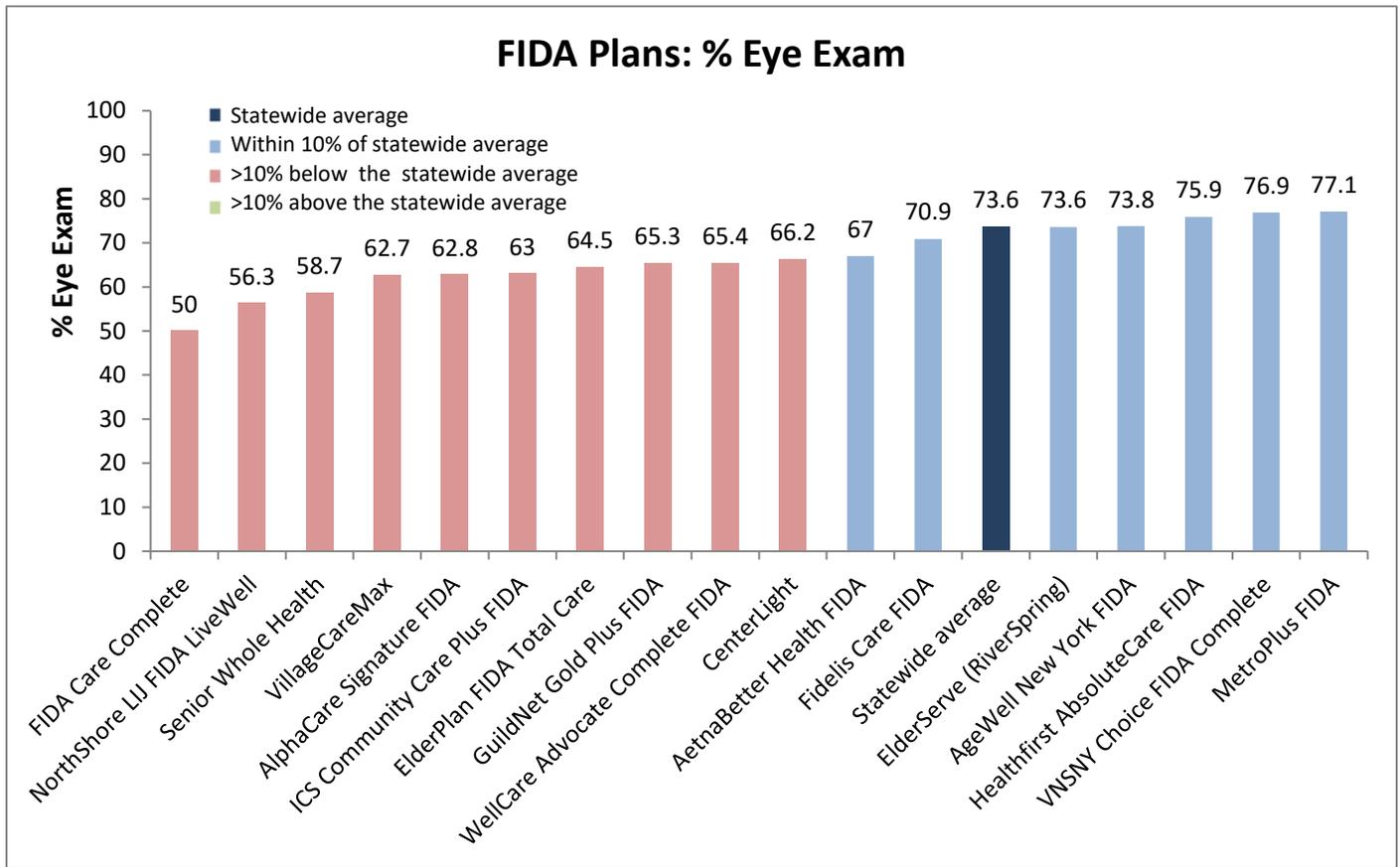


*Rate reflects data from one assessment completed.

FIDA

The statewide average for **eye exams** increased slightly from 73.1% to 73.6%. Seven FIDA plans had rates for this indicator that were within 10 percent of the statewide average, as illustrated by **Figure 19D**. Six of those plans had rates that were within five percent of the statewide average. The remaining ten FIDA plans had rates that were greater than 10 percent below the statewide average.

Figure 19D. Percentage of FIDA members who received an eye exam in the last year.

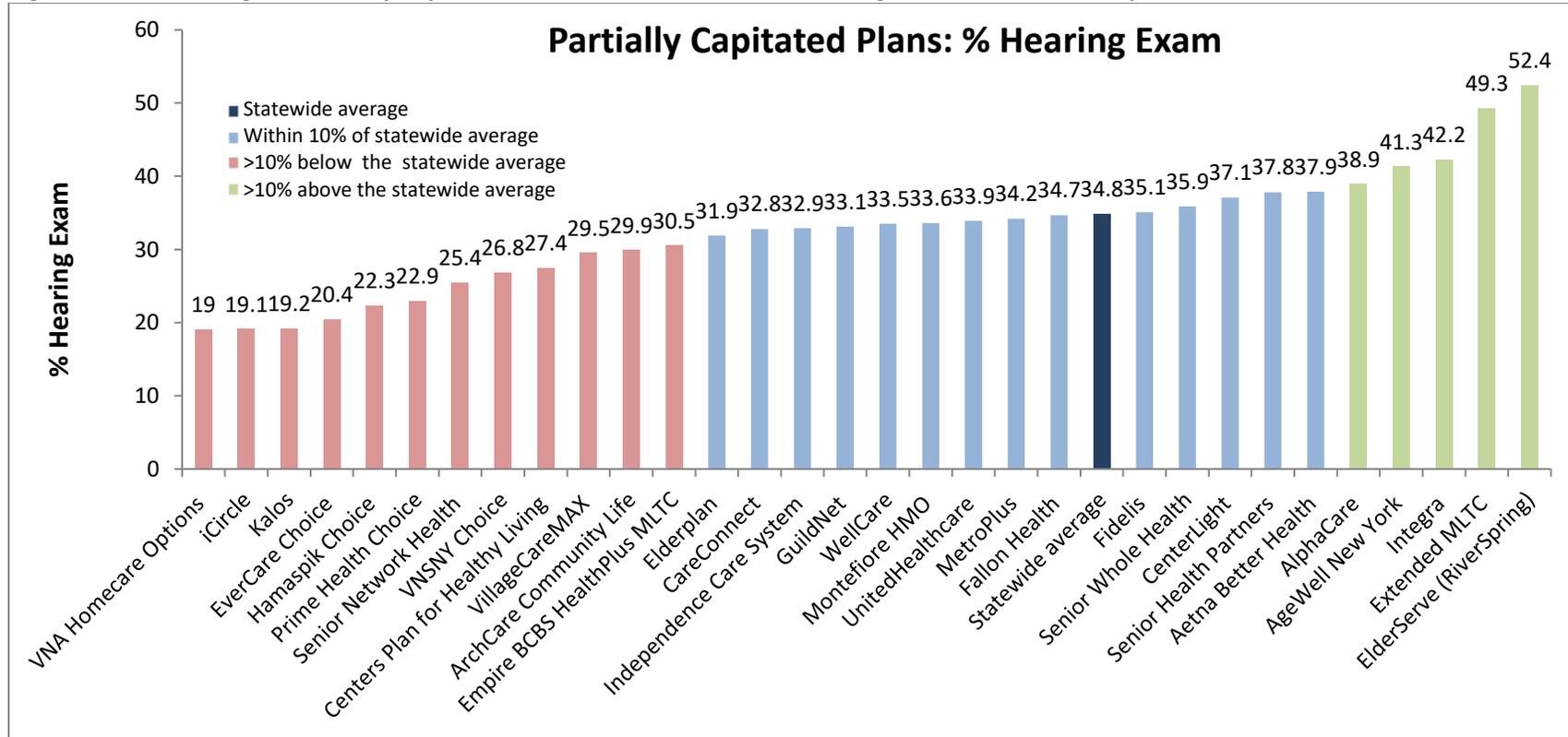


Hearing Exams

Partially Capitated

For **hearing exams**, 34.8% of members statewide indicated that they had a hearing exam in the last two years. This rate slightly increased by one percentage point when compared to the first reporting period. **Figure 20A** shows fourteen partially capitated plans had rates for this indicator that were within 10 percent of the statewide average, and eight of those plans had rates for this indicator that were within five percent of the statewide average. While twelve plans had rates greater than 10 percent below the statewide average, five plans had rates that were greater than 10 percent above the statewide average.

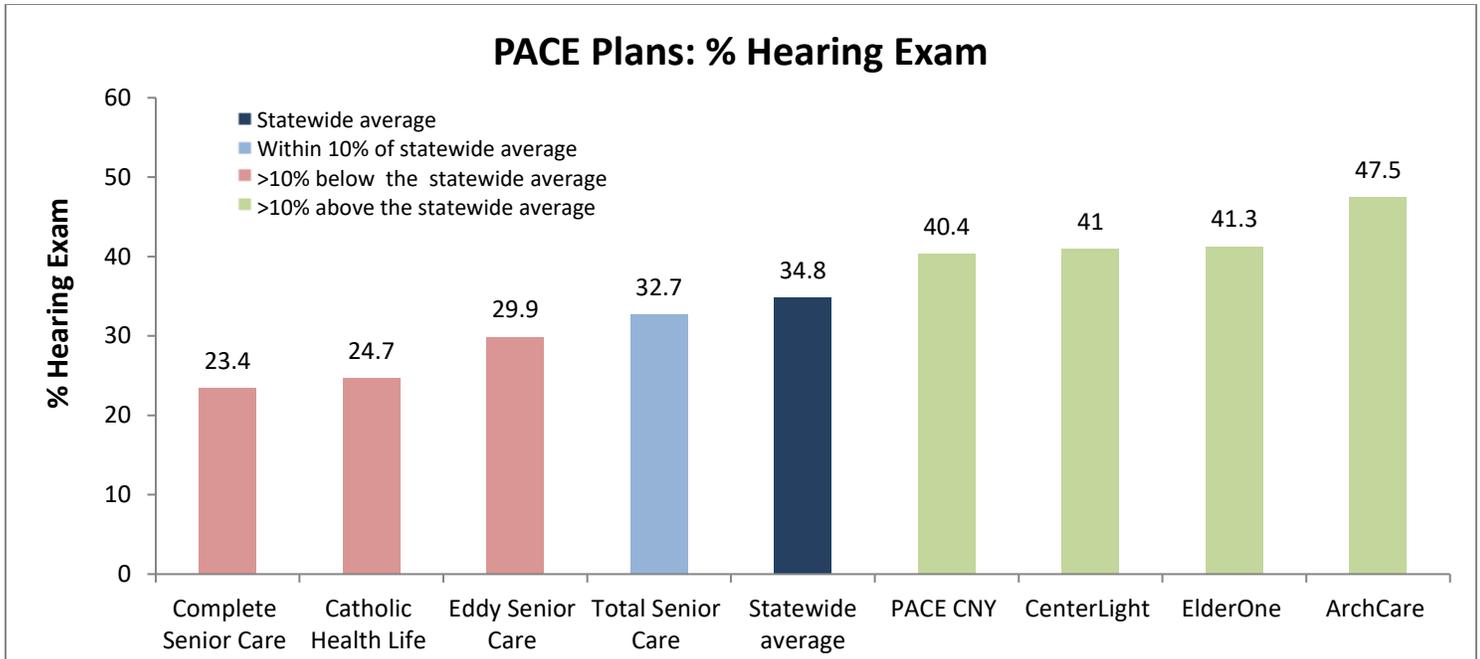
Figure 20A. Percentage of Partially Capitated members who received a hearing exam in the last two years.



PACE

The percentage of members statewide that indicated having a **hearing exam** in the last two years increased one percentage point to 34.8%. As indicated by **Figure 20B**, one PACE plan had a rate for this indicator that was within 10 percent of the statewide average. While three plans had rates that were below the statewide average by more than 10 percent, four plans' rates exceeded the statewide average by more than 10 percent for the hearing exam indicator.

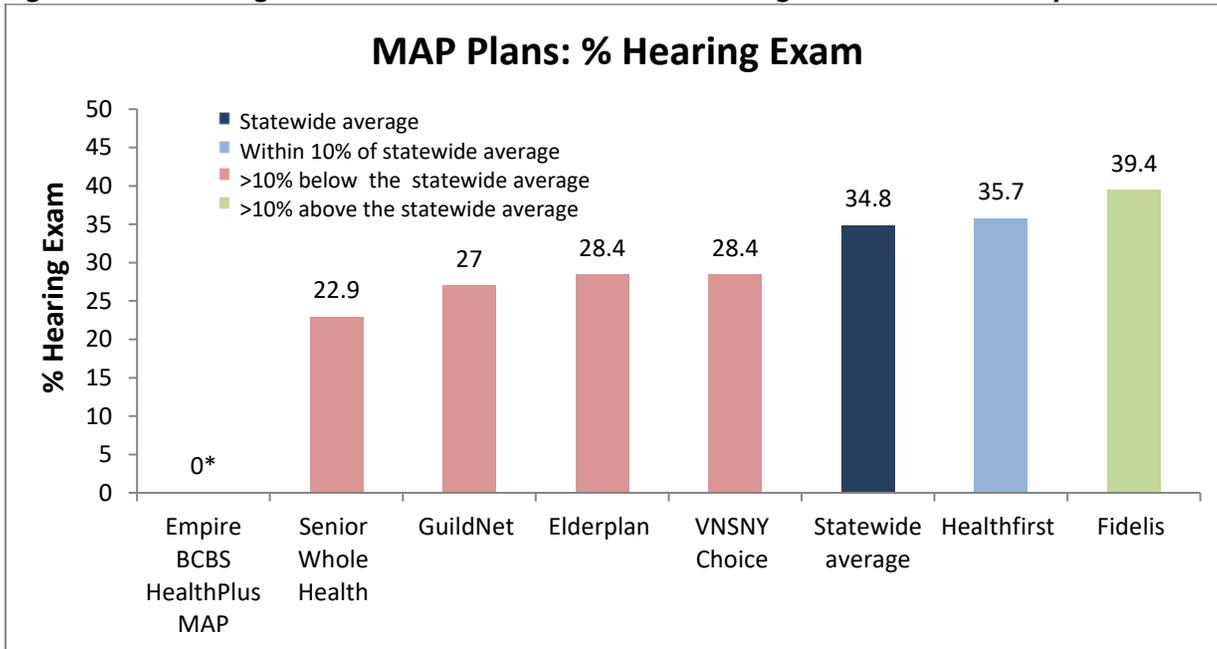
Figure 20B. Percentage of PACE members who received a hearing exam in the last two years.



MAP

The statewide average for **hearing exams** increased one percentage point to 34.8% in the final reporting period. As indicated by **Figure 20C**, one MAP plan had a rate for this indicator that was within five percent of the statewide average. Five plans had rates that were greater than 10 percent below the statewide average. Conversely, one plan's rate for hearing exams was more than 10 percent above the statewide average.

Figure 20C. Percentage of MAP members who received a hearing exam in the last two years.

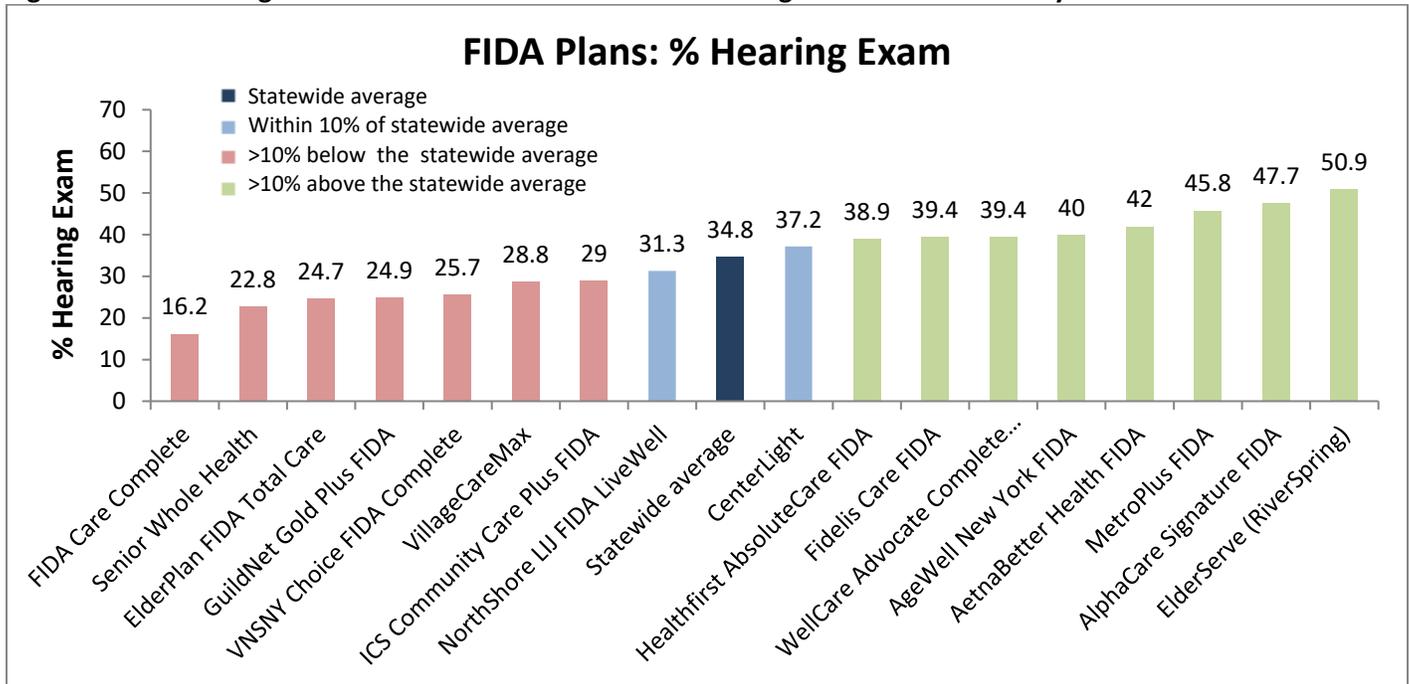


*Rate reflects data from one assessment completed.

FIDA

The statewide average for **hearing exams** increased one percentage point from 33.8% to 34.8%. According to **Figure 20D**, there were two FIDA plans that had rates for this indicator that were within 10 percent of the statewide average. While seven plans had rates for hearing exams that were greater than 10 percent below the statewide average, eight plans had rates that exceeded the statewide average by more than 10 percent.

Figure 20D. Percentage of FIDA members who received a hearing exam in the last two years.

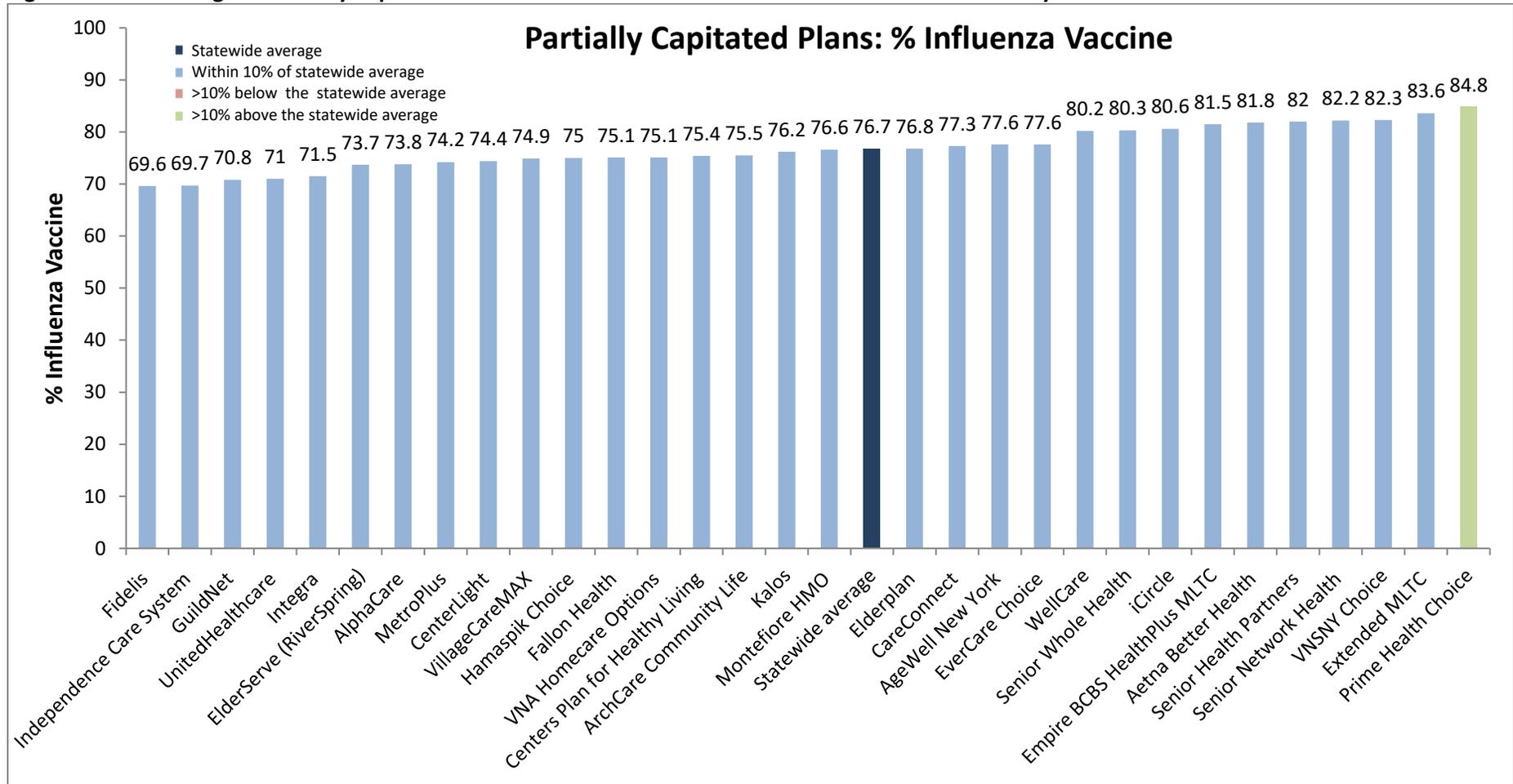


Influenza Vaccination

Partially Capitated

The percentage of members statewide who indicated having an **influenza vaccine** in the last year remained virtually the same when comparing the two reporting periods for 2015 (76.4% vs. 76.7%). As indicated by **Figure 21A**, there were thirty plans whose rates for this indicator were within 10 percent of the statewide average. Of those plans, eighteen plans had rates that were within five percent of the statewide average. Of note, one plan's rate for the influenza vaccine indicator had a rate that exceeded the statewide average by more than 10 percent.

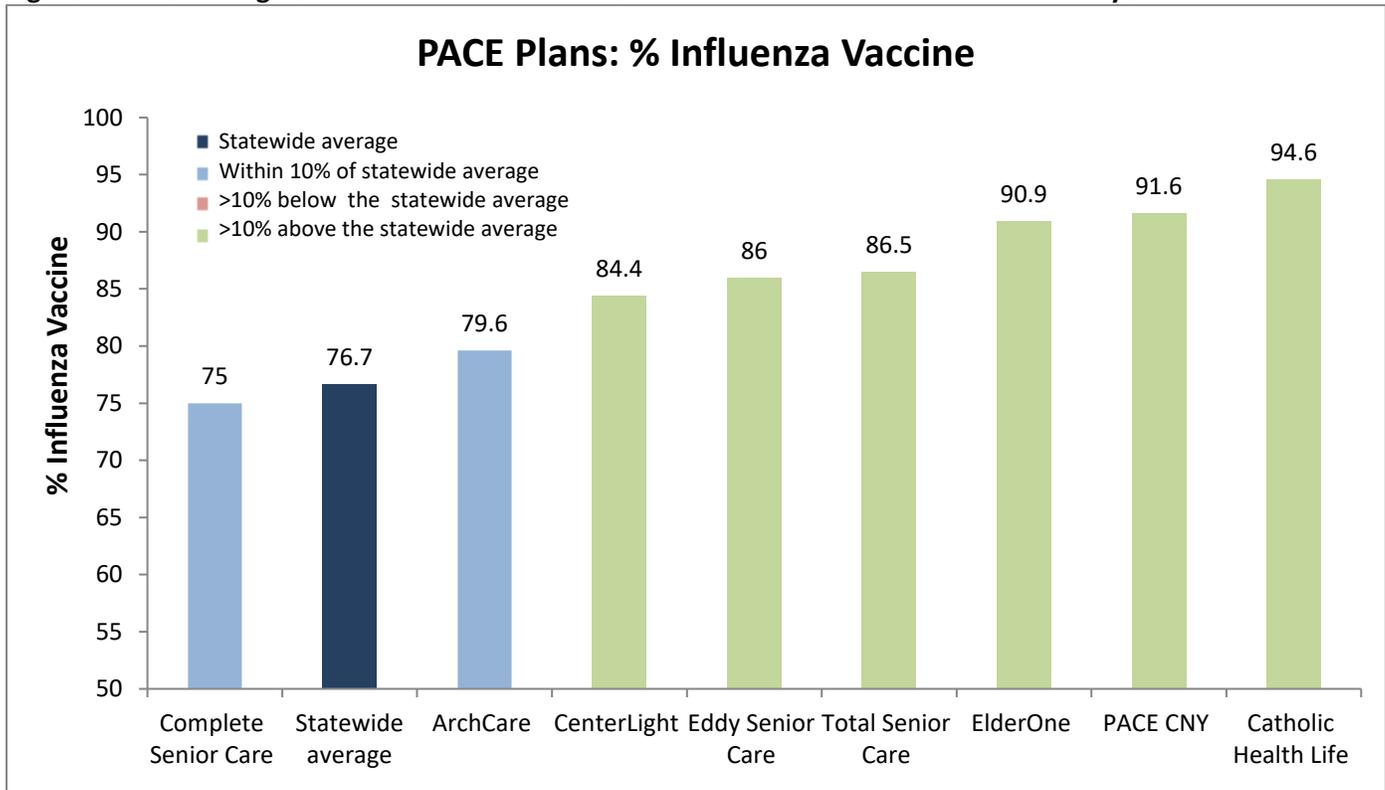
Figure 21A. Percentage of Partially Capitated members who received an influenza vaccination in the last year.



PACE

The statewide average for the **influenza vaccine** indicator remained virtually unchanged at 76.7%. As indicated by **Figure 21B** below, two PACE plans had rates that were within 10 percent of the statewide average. The remaining six PACE plans had rates for this indicator that exceeded the statewide average by more than 10 percent.

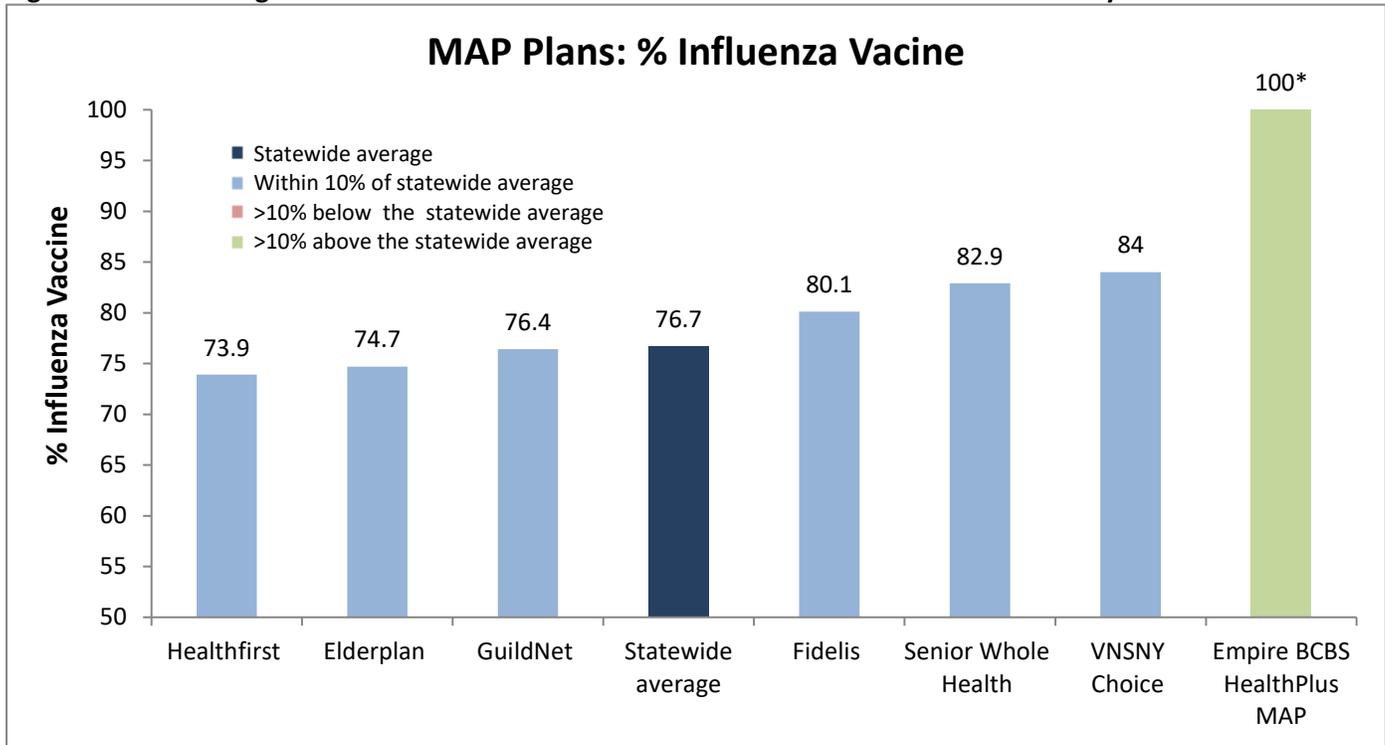
Figure 21B. Percentage of PACE members who received an influenza vaccination in the last year.



MAP

The statewide average for **influenza vaccines** remained virtually unchanged at 76.7%. As shown in **Figure 21C**, six MAP plans had rates for this indicator that were within 10 percent of the statewide average and four of those plans had rates within five percent of the statewide average. One plan’s rate for flu vaccines exceeded the statewide average by more than 10 percent.

Figure 21C. Percentage of MAP members who received an influenza vaccination in the last year.

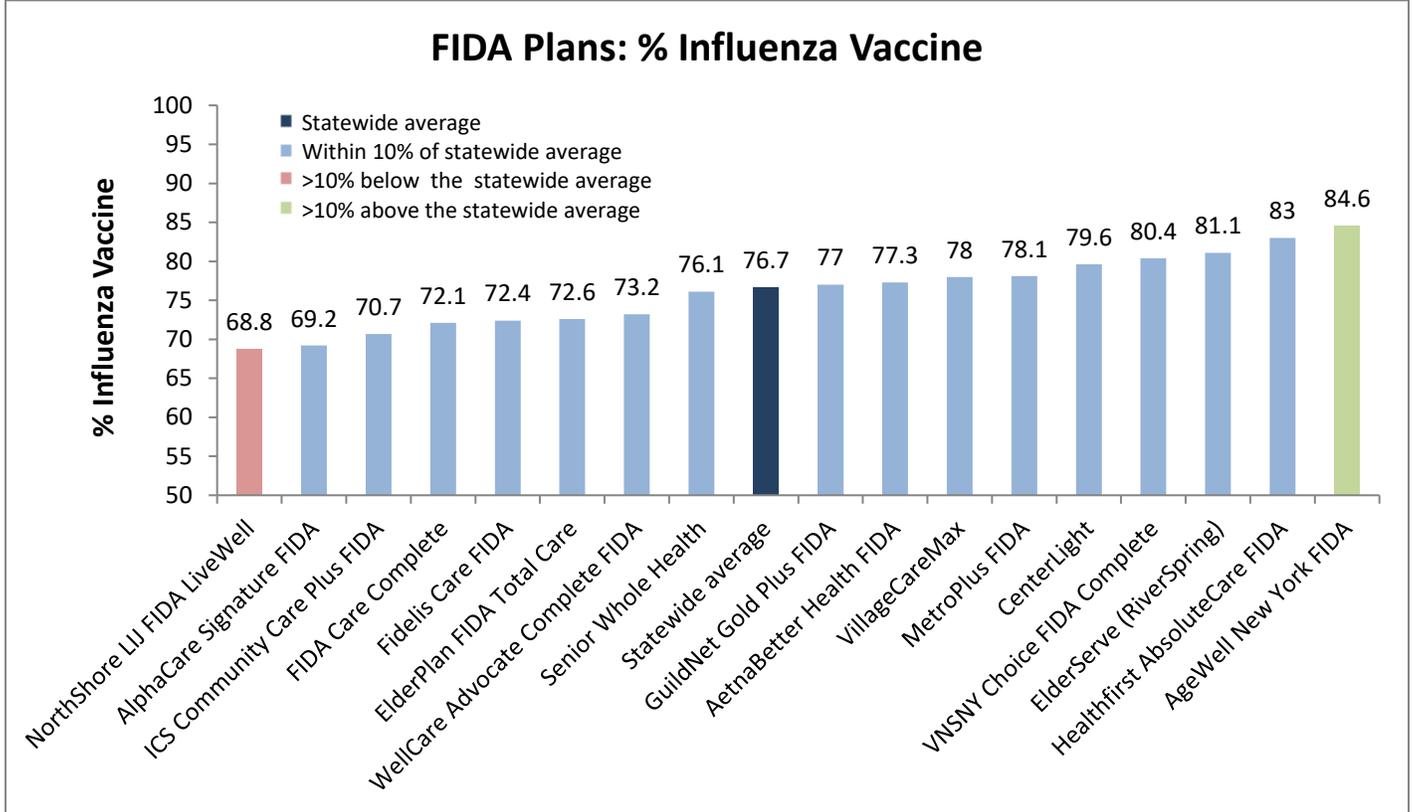


*Rate reflects data from one assessment completed.

FIDA

The statewide average for **influenza vaccines** remained virtually unchanged from the initial to the final reporting period (76.4 vs. 76.7%). **Figure 21D** illustrated that fifteen plans had rates for this indicator that were within 10 percent of the statewide average, eight of which had rates that were within five percent of the statewide average. While there was one plan whose rate fell below the statewide average by more than 10 percent, a different plan had a rate that was greater than the statewide average by more than 10 percent.

Figure 21D. Percentage of FIDA members who received an influenza vaccination in the last year.



Section Six: Performance Improvement Projects

MLTC plans conduct performance improvement projects (PIPs) on an annual basis. Beginning in 2015, given the rapid expansion of the Managed Long Term Care (MLTC) program, IPRO and the NYSDOH proposed that the plans conduct common-topic PIPs, in order to foster collaboration across plans, with the common goals of achieving project success and improving the quality of care for vulnerable populations. Topic consideration was based upon IPRO's review of data provided by the NYSDOH, largely derived from the most recent Community Health Assessment (CHA) submissions, as well as the most recent MLTC Satisfaction Survey results. **Figure 22** represents the project topics that were selected by each plan in 2015. PIPs were not required in 2015 for the FIDA product due to the newness of the program.

Figure 22: 2015 Common-Topic PIP Selections by Plan

Plan Name	2015 PIP Topic
Agewell New York	Advance Directives
CenterLight Select/Pace	Advance Directives
Centers Plan for Healthy Living	Advance Directives
Extended MLTC	Advance Directives
Integra	Advance Directives
MetroPlus	Advance Directives
CareConnect	Advance Directives
United Health Care	Advance Directives
VNSNY	Advance Directives
Eddy	Depression Management
VNA Homecare Options	Depression Management
Complete Senior Care	Emergency Preparedness
Elant Choice	Emergency Preparedness
Senior Network Health	Emergency Preparedness
Aetna Better Health	Falls
AlphaCare	Falls
Catholic Health LIFE	Falls
ElderServe (RiverSpring)	Falls
Emblem Health (HIP)	Falls
Empire Blue Cross Blue Shield HealthPlus	Falls
Independence Care System	Falls
Montefiore HMO	Falls
PACE CNY	Falls
Senior Health Partners	Falls
Senior Whole Health	Falls
Total Aging in Place	Falls
Fidelis	Pain Management
WellCare	Pain Management
ArchCare Community Life and Senior Life	Preventative Screenings (Dental Exams)
Hamaspik Choice	Preventative Screenings (Dental Exams)
VillageCareMAX	Preventative Screenings (Dental Exams)
Total Senior Care	Preventative Screenings (Eye Exams for Diabetics)
Elderplan Homefirst/Elderplan MAP	Preventative Screenings (Eye Exams)
GuildNet	Preventative Screenings (Eye, Ear, Dental Exams)
Independent Living for Seniors (ElderOne)	Preventative Screenings (Dental Exams)

Advance Directives

Individuals are encouraged to participate in healthcare decisions; individuals unable to make these decisions have the right to designate other individuals to act on their behalf. An advance directive, such as a health care proxy or living will, is a document utilized for this purpose. The absence of advance directives can present barriers to care for an individual, since his or her wishes are unknown. There were 9 plans that conducted Advance Directives PIPs in 2015.

AgeWell New York: "Advance Directives"

Advance Directives are a significant component in the care planning process for elderly members living in the community. Based on a 2014 Advance Directives report generated with data from Care Compass, only 52% of AgeWell New York's membership (2,080 out of 3,978) at the time had an Advance Directive in place compared to the MLTC Statewide average of 66%. The objectives of the PIP were to ensure that 95% of the membership will have a documented discussion of Advance care planning and to ensure that at least 75% of members will have an Advance Directive in place. The PIP measured the percentage of members with documented Advance Directive discussions and the percentage of members who had a completed Advance Directive document. Interventions included educating members about advance directives and developing care management documentation of Advance Directives to better coordinate service in relation with member preferences. Demonstrated improvements were seen through increasing discussions regarding Advance Directives with members. This indicator increased to nearly 90% of the plan's population having an Advance Directive discussion. Although the goal to achieve 75% compliance with having a Completed Advance Directive wasn't reached, an increase from 4.5% to 66.3% proved to be significant in determining the success of the project.

CenterLight Healthcare—PACE & Select: "Improving the Rates of Members with an Advance Directive"

CenterLight has determined that advance care planning discussions with healthcare professionals do not occur regularly for its predominantly elderly and chronically ill population. As a result, the rate of members with an Advance Directive is lower than the NY statewide average. PIP objectives were to (1) increase the rate of CenterLight Select MLTC members with an executed Advance Directive by 10%, and to (2) increase the rate of CenterLight PACE members with an executed Advance Directive by 5%. Outcome measures were the rate of CenterLight Select and the rate of CenterLight PACE members with an executed Advance Directive. Process measures included the rate of discussion on Advance Directive between CenterLight Select and CenterLight PACE staff and respective members. Intervention highlights included member education and communication among the care manager/nurse manager, the member and the PCP. Using a patient-centered approach, the care manager/nurse manager identified gaps and opportunities to educate members regarding advance care planning. Telephonic outreach to members and home visits by a Nurse or Social Worker were also employed. The process measure rate at the end of 2015 for Select was 28.45 percent compared to the baseline of 23.21 percent. For PACE, the process measure rate remained stable in 2015 with baseline and re-measurement rate at 77 percent. Although, there was some improvement on the process measure, it did not achieve the expected impact of increasing the outcome measure of increasing the executed advance directive. The PIP for both Select and PACE will be extended to 2016 to analyze and better understand the impact of the EMR implementation and staff compliance on interventions.

Centers Plan for Healthy Living: "Addressing and Improving Advance Directives in the MLTC Population"

According to the Department of Health and Human Services 2008 report to Congress on advance directives, an individual's preference for where they wish to spend the end of their lives are often not met. The 2014 NYS Managed Long Term Care report, based on survey information for satisfaction with experience of care, indicated that the statewide average of MLTC members with an actual document appointing for health decisions was 66%. The IPRO 2015 MLTC satisfaction survey results indicated that 67% of all MLTC respondents and 61% of Centers Plan respondents reported that their health plan has talked to them about appointing someone to make health care decisions for them if they are unable to do so. The two goals of the PIP were for 100% of all Plan members to receive Advance Directive (AD) education and to have a completed AD document for greater than 66% of members who have been enrolled in the Plan for over one (1) year. Project indicators were the percentage of enrolled members who had documented initial discussion regarding Advance Directives and the percentage of members who have been enrolled for one year or longer and have a fully executed Advance Directive document. Intervention highlights included deployment of the "Five Wishes" Advance Care Planning Tool to nurses, care management field nurses, and social workers to utilize for discussion with members. Centers Plan was successful in achieving an increase in member education on advance

directives from 75% to 99% throughout 2015, and came close to achieving the project goal of 100%. Centers Plan has shown slow but steady improvement in having members complete a fully executed advance directive over the course of the project in 2015. First quarter results indicated that 22% of membership enrolled over one year had an executed advance directive, which increased to 28% in the fourth quarter. Centers Plan did not attain the original designated goal of 85% of membership having a complete advance directive and revised the goal to >66%. The Plan planned to continue the PIP through 2016.

Extended MLTC: "Advance Directives"

Advance Directives (Health Care Proxy, Living Will, etc.) are considered to be important tools for promoting patient autonomy, dignity, reassurance, and empowerment. However, despite acceptance of advance care planning and advance directives (AD) in the care of older patients, less than 30% of Americans have advance directives, and those with chronic disease may have similarly low completion rates. The Plan chose the topic of Advance Directives to determine efficient ways of promoting advance directives and to increase rates of AD completion among Extended MLTC (EMLTC) members, the majority of whom are 65 and suffer from multiple chronic conditions. The goal of the PIP was to determine efficient ways of promoting advance directives and to increase rates of AD completion by: (1) improving the percentage of members who report completing advance directives from 46.6% to 65%, (2) improving the percentage of members for whom the Plan has a copy of the AD on file from 14.3% to 70%, and (3) maintaining the percentage of 100% of members with a documented AD discussion. Interventions were planned based on anticipated barriers (i.e. lack of knowledge regarding ADs, language barriers, literacy levels, and insufficient access to fax/copy). Specific interventions were focused on member and caregiver education (oral and written), as well as ongoing encouragement and guidance in completion of ADs. To address language barriers, all educational materials and AD forms were provided in member's primary language. To address literacy issues, samples of completed HCP forms were created in 4 prevalent languages. Results of the PIP indicated the percentage of members that reported completing an AD increased by 12.3 percentage points to 58.9%, but did not meet the goal of 65%. For the second indicator, the percentage of members with an AD on file with the Plan increased by 58.6 percentage points to 72.9%, exceeding the goal of 70%. Finally, the percentage of members for which a discussion of an AD is documented remained unchanged at 100%.

Integra MLTC: "Improving the Rate of Advance Directive Documentation in Members' Charts"

The Advance Directive initiative was outlined and designed to encourage Integra MLTC members to participate in their care planning by effectively understanding the advantage(s) of appointing a representative to make healthcare decisions in the event that he/she becomes impaired. Most often, family members are expected to make healthcare decisions on behalf of a loved one without knowing any of his or her preferences. In an attempt to avoid these types of situations, Integra MLTC adopted the Advance Directive Initiative and the Five Wishes program to promote education to staff, members, families, and caregivers. The projected goal was to achieve a rate of compliance of at least 80% (member charts with documented Advance Directive discussions OR an AD document in place). Indicators for this PIP included: (1) percentage of new enrollees with documented advance directives upon enrollment and (2) percentage of reassessed members with documented advance directives at the time of reassessment. Intervention highlights included Integra's Care Management System "Care Compass" being enhanced to capture proper documentation related to advance directive discussions in the member record, advance directives comprehensive training program was developed and adapted in order to provide guidance and tools to the Plan's clinical staff, and advance directives re-training being provided for outsourced assessment vendors. Results for indicator 1 showed a 0.8 percentage point increase to 0.8% between baseline and final measurement, and results for indicator 2 showed a 21.6 percentage point increase to 21.6%; 80% compliance for both indicators was not met. While Integra MLTC did not meet the established goal, this performance improvement project has established a roadmap for future efforts of the Plan. All applied interventions proved to be successful as Advance Directive discussion(s) are now more frequently documented by the Care Manager in the member record during the monthly call.

MetroPlus: "Improving Collection and Documentation of Advance Directives in the MLTC Population"

The purpose of this project was to promote advance directive discussion with the member's provider and improve collection and documentation of such among MetroPlus MLTC enrollees. MetroPlus performed poorly on the 2013 HEDIS measure Care for Older Adults, thereby providing the Plan an opportunity to improve rates in this measure, including the sub-measure of Advance Care Planning. The purpose of the study was to promote member discussion of

Advance Directives with their provider and to improve the collection and submission of the member's Advance Directive documentation to the Plan. The PIP's progress was measured by achieving compliance for all of the following objectives for the end of calendar year 2015: member outreach calls, members that had an advance directive discussion with their provider, and members with completed and signed advance directive documents. There were three indicators for the PIP: percentage of members that had a self-reported advance directive discussion with their provider and percentage of members that returned completed and signed advance directive documents. Interventions included assistance of MLTC staff who initiated the discussion about advance directives with members using a script developed for these calls. Outreach calls were followed by a mailing to the MLTC membership. Subsequent outreach calls and mailings were conducted to maximize efforts to ensure that all members were educated on the topic and had opportunities to complete an advance directive packet. As of 12/31/15, a total of 209 (24%) members, out of a total population of 871, indicated they had an advance directive discussion with their PCP. The total number of proxies returned from 4/2/15 to 12/31/15 was 109 (12%) out of a total population of 871. MetroPlus will continue to educate members on the importance of advance care directives through mailings and the availability of advance care forms on the MetroPlus member portal. MetroPlus will also promote the importance of providers' role in initiating and guiding the advance care planning process by making it a routine part of care for all members.

Care Connect(NSLIJ): "Advance Directives"

Advance care planning involves learning about the types of decisions that might need to be made, considering these decisions ahead of time, and letting others know about these decisions by documenting them as an Advance Directive. This project acknowledges the importance and need of increasing membership compliance with having an advance directive. Preliminary plan data suggest that only 49% of the total membership reported having a current Health Care Proxy (HCP). The PIP's objectives were: (1) educate members about end-of-life services and care; (2) encourage individuals to participate in health care decision-making; (3) promote the importance to verbalize health care decisions to family, friends, and health care providers; (4) foster communication and collaboration amongst health care providers with regard to end-of-life care; and (5) obtain supporting documentation that outlines health care decisions made by the member. The indicators and associated goals of the PIP were to increase the percentage of members who were asked if they have a HCP by 6%, as determined by documentation in the care management system of record and to increase the number of member-verified HCPs by 6%, as obtained by verbal communication and documented in the care management system of record. Intervention highlights included care management team education, modification of a HCP template which was made available in multiple languages, monthly calls to members, and organization-wide notification of PIP project goals and objectives. Results indicated a decrease in both PIP indicators, which did not meet the goal of a 6% increase for both indicators. The Plan acknowledged the inability to show significant improvement at the interim stage of the PIP. The Plan would like to enhance data collection to better capture the intervention efforts as well as institute several new interventions to improve results upon remeasurement.

UHC: "Improving the Rate of Executed Advance Directives in the Managed Long Term Care Population"

According to the NY State Department of Health, only 66% of MLTC members have an executed Advance Directive and only 70% of members (or families) report that a conversation has taken place with Plan staff. As of December 2015, UnitedHealthcare Personal Assist had 1,141 members and the rate of members reporting having an Advance Directive was 4.7% (as reported via CHA data). One of the objectives of this project was to assure that all members at either initial assessment or at a six month (or change in status) reassessment have a discussion with nursing staff about the importance of Advance Directives. Another objective was to assure that the rate of members who currently have an Advance Directive improved from the baseline to 50%. The eligible population for each interim review was a sample of all members who had an assessment in the three months prior to the review. Project indicators for the PIP included the percentage of all members with an executed advance directive and the percentage of all members with documented education/discussion of advance directive. Intervention highlights included training staff and providing tools to facilitate discussions with members and their families/caregivers about advance directives. In 2015, results indicated that members reporting having an Advanced Directive (indicator 1) increased by 13.41 percentage points from Q1 to Q4, but did not meet the 50% goal. Documentation of a conversation with a Plan nurse met the goal and improved in Q2 and Q3, but fell below goal of 50% by 7.38 percentage points in Q4.

VNSNY: “Improving the Rate of Advance Directives Discussed with VNSNY Choice MLTC Members”

An integral part of the VNSNY CHOICE experience entails a detailed assessment and understanding of a member's care needs to provide the right level of care and coordination at any given time, and in establishing a familiarity with the member's desires for their health care and overall well-being. As members continue to age or become debilitated, it becomes a central and important conversation and aspect of care to reinforce standing Advanced Directives for appropriate member care coordination and service delivery, respect for the members' wishes and improvement in quality of life. The objectives of the PIP were to improve the rate of advance directives discussions with VNSNY Choice MLTC members and to increase the number of advance directives on file for each member. Project indicators were the rate of advance directives, number of advance directives on file, and discussion of advance directives with members 3-4 months post initial CHA assessment and re-assessment. Interventions included implementation of an education module regarding the different types of advance directives, dissemination of brochures to members and/or caregivers regarding advance directives, and a provider letter to remind providers of the importance of advance directives. Interim results were not available for review in the PIP. The PIP states the data for indicators #1 and #2 “are pending and will be retro-reported once the data are available in Q2 2016. Calendar Year 2015 and Q1 2016 data will be reported in Q2 2016”. The Plan reported that the delay in reporting results was attributed to the implementation of a new Care Management system that hampered data collections efforts for indicators #2 and #3.

Depression Management

Depression is a valid and treatable medical condition and is not a normal part of aging. Older adults are at increased risk for depression, and the risk is higher for older adults with two or more health conditions. Across all ages, depression has been found to be more prevalent in people who also have other illnesses or whose functions and activities of daily living have become limited. These groups of people comprise the majority of MLTC membership. Depression can negatively impact other physical illnesses and quality of life. Healthcare personnel who oversee care of the elderly may not readily recognize or treat patients with depression. This is likely due to the presentation of depression in the elderly, which is often atypical—insomnia, anorexia, and fatigue—as opposed to the typical depressed mood reported by the younger depressed patient. Two plans conducted Depression Management PIPs in 2015.

Eddy Senior Care: “Depression Management”

Depression in the elderly is a valid and treatable medical condition and is not part of the normal aging process. It is a complex illness which is compounded by variables such as cognitive impairment, incontinence, chronic medical conditions, and significant personal and social losses that can occur with aging. Symptoms of depression in the elderly population can often be more somatic in nature, such as weight loss, chronic pain, gastrointestinal issues, or headaches as opposed to more commonly identified traditional symptoms of irritability, fatigue, sadness, or depressed mood. Through addressing depression, there is an opportunity to improve the quality of care of Eddy participants and ultimately the quality of their lives. The objective of the PIP was to screen 100% of the eligible population with the Patient Health Questionnaire – 9 (PHQ-9), a validated depression screening tool. Participants who scored a 10 or above were referred to their primary care physician for a medical evaluation and treatment. Intervention highlights included educating staff members on depressive symptoms and signs, screening members with the PHQ-9, member follow-up, educating members and family, and a “Living with Depression support group” implemented by the social work department. Eddy Senior Care met its objective of 100% compliance with screening participants utilizing the PHQ-9 and referring those individuals that scored a 10 or more on this tool to a PCP. Only 6 out of 9 participants referred were actually seen by a PCP and 4 of the 6 that were seen by the PCP accepted treatment for depression.

VNA Homecare Options: “Screening and Care Management for Members with Depression”

The 2014 Uniform Assessment System CHA data for VNA Homecare Options (VNAHO) shows only 6.2% of members have a diagnosis of depression. This is lower than the 15%-25% prevalence of depression in the managed care population literature. Depression may be underreported and members may benefit from enhanced screening and care management. Project objectives were to improve screening and recognition of depression in VNAHO members, enhance care management interventions for members with depression, and to improve medication adherence in members with depression. Project indicators were the depression screening rate of eligible new enrollees, PHQ9 scores that were greater than or equal to 10 and had an improved follow-up score after intervention, PHQ9 scores between 5 and 9 and had an improved follow-up score after intervention, treatment with medication, and medication compliance.

Intervention highlights included screening new eligible members for depression using the PHQ9, notifying member's PCP and follow-up for members with a PHQ9 score greater than or equal to 10. Additionally, medical record reviews were completed to determine whether appropriate follow-up was completed and members who were started on anti-depressants were assessed for compliance. Results indicated that 72% of members were ineligible for screening because they had a diagnosis or treatment of depression, despite the Plan reporting that only 6.2% of members had a diagnosis of depression on the 2014 CHA, and 37% of members are taking an antidepressant. The PIP reports that new members were not previously screened with a standardized tool, and therefore, the screening rate for new eligible members improved 100% from baseline. A follow-up, second PHQ9 screening score improved for 6 of 8 members with an initial screening score > 10 (75%) and for 5 of 8 members (63%) with an initial screening score of 5-9.

Emergency Preparedness

Many MLTC members live alone in a community environment and in many instances have multiple co-morbidities and need assistance with activities of daily living. Such members are among the most vulnerable in an emergency situation, such as a hurricane or major snowstorm resulting in power and/or telephone outage, a house fire, a flood, or an adverse incident such as a fall. As such, MLTC members should have emergency plans in place, for maintaining personal safety in the event of an incident. Three plans conducted Emergency Preparedness PIPs in 2015.

Complete Senior Care: "Emergency Preparedness in the Home"

Emergency Preparedness is the chosen topic by Complete Senior Care to provide to home based participants with preparation for emergencies which may impact them in their home. Home care presents a unique area to emergency preparation within the scope of continuum of care. The goal of the PIP was to provide participants, family members, caregivers the tools they need for preparation and response. This includes the following emergencies: Weather related emergencies, Utility failures, and Communications failures. Intervention highlights included: disseminating emergency preparedness documents, assuring each participant has emergency preparedness supplies on hand, and ensuring participants with life support devices that require electricity were registered with utility companies. The eligible population for the PIP was all participants who currently live with or without assistance in their home (n=100). The PIP goal was to attain 100% compliance for all indicators: (1) percentage of staff members educated on home care emergency preparedness, (2) the percentage of participant or caregivers educated on emergency preparedness activities, (3) the percentage of participants with the necessary core documents, basic information sheets, and list of recommendations for the home, (4) the percentage of participants on life support devices requiring electricity who are registered with utility companies, (5) the percentage of participant care plans that include the NY State established "priority" list designation, and (6) the percentage of participants who, at 6 months have retained emergency preparedness information and have an established location for documents, supplies, flashlights, etc in place. The plan succeeded in attaining 100% compliance for all indicators with the exception of indicators 4 and 6.

EverCare Choice: "Emergency Preparedness Education"

Emergency Preparedness is a topic of great importance to EverCare Members, who tend to be among the most frail and needy in the community. Emergency events can be stressful and affect the member's ability to respond quickly and appropriately when such responses are required. The objective of the PIP was to ensure that all members have received education regarding Emergency Preparedness and that all members have readily accessible information in the form of a Personalized Disaster Plan to help guide them in the event of an emergency. Project indicators were the percent of members with written materials in their home, percent of members receiving face to face communication during the first month of enrollment, and percent of members of receiving face to face communication during recertification. PIP interventions included creating a personal care plan for each member based on publically available information from nationally recognized sources. Additionally, Care Managers were trained on the information and their roles in the project, leadership at each congregate care setting was met with to share the program and determine whether or not members would receive their education and materials from the Plan or from the congregate care setting. New members received this information during the first month of enrollment, and existing members received this information during the recertification assessment. The final population for the PIP was the year-end census of 856 members (296 newly enrolled, 560 existing members). The ending completion rates (reflecting the number of members who received face-to-face emergency preparedness education and a Personal Emergency Plan) are as follows: All members: 79%, New

members: 72%, existing members: 82%. While the initial aggressive goals were not met, the results represent a significant increase in member to Plan collaboration and communication.

Senior Network Health: “An Intervention to Improve Disaster Planning Readiness for Chronically Ill Patients”

Recent national and international events have brought the importance of disaster planning to the forefront of the nation’s concerns, especially in the case of special needs and chronically ill persons, who often have limited resources available to them. Disasters that could affect members in Senior Network Health’s service area include blizzards, fires, residential structural damage, rainstorms, tornadoes, floods and disruption of water, electrical and transportation systems, as well as terrorist activity. The PIP’s objective was to provide each Senior Network Health member with the opportunity to develop an emergency/disaster plan, to keep it in a safe place, and to update it when a significant change occurred. Project indicators were (1) Percentage of members eligible for emergency planning education and preparation of documents, (2) percentage of members having written disaster plans in place, (3) members actually offered emergency planning education and documentation, (4a) percentage of members completing an emergency plan education and documentation, (4b) percentage of members declining emergency planning, (5) percentage of members having a plan in an accessible area, (6) percentage of members verbalizing the understanding of established emergency plan at 6 months, and (7) percentage of members having an appropriately updated plan at 6 months. Intervention highlights included creation of an easy to use form that could be scanned into Senior Network Health’s EMR system, educating staff Care Managers, querying members or their surrogates as to the existence of a formal disaster plan for their family unit, and reporting progress in the EMR. All indicators improved during the study period. The study indicated that with a moderate investment in time and limited financial cost disaster planning can be integrated into the member’s awareness and documentation updated as needed and placed in a secure location for retrieval as necessary. Improvements in document accuracy would be aided by having an integrated electronic medical record.

Falls

Falls are a significant health concern. Literature shows that one out of three older adults fall each year but less than half talk to their healthcare providers about it. Among older adults, falls are the leading cause of fatal and non-fatal injuries. Twenty to thirty percent of people who fall suffer moderate to severe injuries such as lacerations, hip fractures, and head traumas. Twelve plans conducted Falls PIPs in 2015.

Aetna Better Health: “Fall Prevention and Management”

Falls are the leading cause of injuries among older New Yorkers and are the leading cause of both fatal and nonfatal injury hospitalizations among residents aged 65 or older. A review of Aetna Better Health’s MLTC population in the New York specific Uniform Assessment System CHA data submission for the January to June 2014 period reflects a fall rate of 14%, which is slightly above the fall rate of 12% recorded among all MLTC plans in the state. The goal of the PIP was to reduce the incidence of falls to align with the state benchmark of 12%. Indicators included the proportion of high fall-risk members, those high falls-risk members who receive interventions, and the effectiveness of those interventions on anxiety levels of the study cohort who reported a fall. Fall Risk Assessment Tool was completed upon admission to the MLTC and on routine six month reassessment, after which a report could be generated in the Case Management Business Application System. Other interventions included Care Managers developing falls prevention care plan with targeted interventions based on participant modifiable risk factors and Care Manager collaboration with member interdisciplinary care team and PCP. Performance Improvement Project results, to date, indicate a four percentage point decrease in the incidence of falls among Aetna Better Health MLTC members from the baseline rate of 14%. Interim results exceed the target goal of two percentage point reduction in the fall rate, aggregate results for the fall reduction rate is currently at 10%.

AlphaCare: “Decreasing the Incident of Falls in a Managed Long Term Care Population”

It is evident that minimizing falls is important to the MLTC population and addressable. In order to successfully embark on this topic, AlphaCare performed an analysis to identify barriers to the successful implementation of a fall prevention project. Baseline data indicates that 75% of AlphaCare MLTC members with a CHA submitted between January and November 2014 had not experienced a fall in the last 90 days. Compared to the statewide average (SWA) of 88%, this reflects a 13 percentage point difference. AlphaCare’s objective is to reach the SWA by the end of the PIP. The outcome measure for the PIP was the ratio of unique MLTC members who did not have a fall in the 90 days prior to their most

recent CHA to the total unique MLTC members that were assessed in the project period. Records are pulled from the HCS web site and the question on falls in the Community Assessment portion of the CHA was used to measure for no fall 90 days prior to the assessment. Barriers included member compliance, member's perception of risk(s), PCP availability to do assessments or their awareness of the member's risk. Interventions to address the barriers included member-specific outreach based on condition, environment, or limitations, as well as contacting the member's PCP/provider if health condition(s) may have been a contributing factor. Interim results indicated a 9.1 percentage point increase of the No Fall rate compared to baseline.

Catholic Health LIFE: "Independence through Integration of Exercise in Daily Activities in a Program of All-Inclusive Care for the Elderly (PACE)"

Exercise is known to be important for maintaining overall health and preventing functional decline in older adults. However, adherence to any type of exercise program in older adults is about 66% and only about 25% for home based exercise programs. Older adults involved in the Program of All Inclusive Care for the Elderly (PACE) are encouraged to perform recommended home exercise, but rarely do. The PIP objectives were to answer the following five questions: (1) Will the treatment group improve their strength and fear of falling after the intervention compared to the control group?, (2) Will the treatment group improve their functional activities of daily living (ADL) and instrumental activities of daily living (IADL's) after the intervention compared to the control group?, (3) Will the treatment group report improvements in health and quality of life after the intervention compared to the control group?, (4) Will the treatment group have fewer falls after the intervention compared to the control group?, and (5) What will be the self-reported participation rate of the BFE in individuals in the treatment group? Instruments to measure outcomes included The Activities-specific Balance Confidence (ABC) Scale, Functional Independence Measure (FIM), WHO (Five) Short Physical Performance Battery, and Well-Being Index. Interventions included tailored instructions provided to 17 participants by occupational and behavioral therapists using BFE (University at Buffalo Functional Exercise) every 2 weeks for 12 weeks. The 16 participants in the control group were asked to continue with their usual activities. The treatment group significantly improved functional scores ($p=.03$), and improved in strength, quality of life, and balance confidence marginally better than the control group, although without statistical significance at $p=.05$. Fall rates were similar in both groups for the first 6 weeks; however, during the second 6 weeks, no participants in the treatment group fell and the difference was significant ($p=.007$). At post-test, 100% of the treatment group were performing exercise on a regular basis and stated that they wanted to continue exercising at home after completion of this study, compared to 69% of the control group.

ElderServe Health: "Preventing the Re-Occurrence of Falls by Educating & Engaging Member's Personal Care Workers."

As a Managed Long Term Care Plan (MLTC), ElderServe Health members have personal care workers (PCWs) who provide long term care support services. ElderServe has proposed educating PCWs where the member resides, to identify situations that may lead a member to be at risk for falls and provide the PCW with the information to mitigate potential risks in the home environment. The Centers for Disease Control reports that each year, one in every three adults age 65 and older falls. Falls can cause moderate to severe injuries, such as hip fractures and head traumas, and can increase the risk of early death. The objective of the PIP was to reduce the rate of fall re-occurrence for members with a history of falls by educating the member's PCW(s) on falls risks and prevention. The Plan estimated its baseline rate of members identified with an initial fall may re-fall at an annual rate of 22%. The goal of the PIP is to reduce the rate of reoccurrence of falls by 20%. Project indicators were the percentage of members who reported a fall and the percentage of members who did not experience a fall-reoccurrence. The population used in this study was Managed Long Term care (MLTC) members residing in the Plan's Brooklyn region, where the largest segment of ElderServe's members resides. PIP interventions included PCW outreach to members to educate them on identifying fall risks and actions to reduce or mitigate falls, PCW performing a Home Safety Assessment, and interviews conducted with PCWs to evaluate the effectiveness or need for durable medical equipment, arrange for medication reconciliation, and obtain feedback from PCWs regarding the status of the member. The fall rate was calculated using the CHA screening tool which showed that the Plan's falls rate was 6%; 1 percentage point higher than the statewide average of 5%. In members with a history of fall, the rate of repeat falls was 7.9% in 8 months for an annual rate of 11.9%. This was significantly lower than the anticipated rate.

Empire Blue Cross Blue Shield Health Plus (formerly known as Amerigroup): "Reducing Fall Risk through Balance Confidence Screening & Intervention"

Falls are a common and serious risk with an aging population. In community based populations, almost half of all falls happen in the home. The Plan's Uniform Assessment System CHA data from January-June 2015 show that the member falls rate was below the State average for falls but this is still an important topic the Plan's membership. The objective of the PIP was to reduce new enrollee fall risk by increasing balance confidence for at risk members through falls prevention education and implementation of a home exercise program. The goals of the PIP were to increase balance confidence among fall risk members by 10% and to reduce the fall rate for fall risk members by 5%. Indicators included Fall Efficiency Scale (FES) score pre and post PIP, as a proxy for balance confidence, and the CHA fall rate. Interventions included educating Plan staff and Certified Health Home Agency (CHHA) staff to the project and the home exercise program. Additionally, Case Managers made monthly contact calls to members to address balance confidence issues, educating members on home environmental factors influencing balance confidence, providing ongoing member support and motivation, and assessing for falls and follow-up with members' medical provider and the CHHA. The balance confidence FES score decreased from a baseline rate of 79% to the final rate of 62% which represents a 17 percentage point (22%) decrease. The PIP exceeded the goal of a 10 percent decrease from the baseline rate. The falls rate decreased from a baseline rate of 40% to the final rate of 22% which represents an 18 percentage point (45%) decrease. The PIP exceeded the goal of a 5 percent decrease from the baseline rate.

Fallon Health Weinberg MLTC: "Fall Mitigation"

Falls have been identified as one of the leading adverse events among the Fallon Health Weinberg program members. Falls among the elderly may account for injury, decline in functional status, hospitalizations and deaths. Studies have shown that the risk of fall increases with age. Thirty percent of people over the age of 60 fall every year. Fifty percent of people over the age of 80 fall every year. PIP objectives included: to reduce the number and severity of falls with the current membership, to create a mechanism to identify high risk fall members and implement preventive measures upon enrollment and after as members age, to enhance the communication surrounding falls with members, family, staff, and providers, and to develop a falls prevention educational workshop. Project indicators were falls with repeat individual members, percentage of members falling, percentage of falls on weekends, percentage of falls sent out to the ER, percentage of falls with fracture, and total number of falls reported. Interventions included adopting the Missouri Alliance for Home Care MAHC 10-Fall risk assessment for all new enrollees into the program, in-home evaluation for members who had a repeat fall and monthly member falls report to ensure follow-up prevention and intervention implementation with sensitivity to those members who had previous falls throughout the year. Comparing baseline results to final results, the Plan showed demonstrated improvement with the rate of falls decreasing from 29% in the 1st quarter (baseline) to 8% in the 4th quarter (final). The 8% fall rate exceeded the goal to reduce the rate of falls below 25%. The PIP also showed demonstrated improvement compared to baseline for the following indicators: decreasing the rate of members with repeat falls, the rate of falls with fractures and the overall number of falls, as well as a significant reduction in the rate of falls on the weekends. It should be noted that the PIP did not establish goals for these indicators. The Plan maintained its performance level for members sent out to the ER for evaluation related to a fall (baseline =34% versus final = 33%), failing to reach the established goal of 5%.

Healthfirst Complete Senior Care & Senior Health Partners: "Reduce the Number of Falls Requiring Medical Intervention"

Falls are a major problem among the adults aged 65 and older. Twenty to thirty percent of falls can cause moderate to severe injuries, and can increase the risk of early death. Many people who fall develop a fear of falling, which may force them to limit their activities, leading to reduced mobility and loss of physical fitness, and discourage them from engaging in their communities. Fortunately, falls are preventable and Healthfirst is taking strides towards reducing the chances of falling among MLTC members and ensuring the safety of each member. Analysis of responses to the Uniform Assessment System CHA questionnaire indicates that about 8% (n=15,245) of members with assessments during the 6-month period (June – November 2014) had a fall severe enough to warrant medical intervention. This analysis also indicates that falls is one of the top reasons for Emergency Room (ER) visits. CHA data from October 2014 showed that 22% (n=75) of the 343 Healthfirst members who reported an ER visit in the previous 90 days attributed the reason for the ER visit to an injury caused by fall or accident in home. The objective of the PIP is to reduce the number of falls requiring medical intervention. The stated goal in the PIP was to attain a rate of 95% for all members whose recent CHA assessment indicated that the member did not require medical intervention for a fall. Project indicators were the percentage of members who did not have a fall requiring medical intervention in the last 90 days and the percentage of members who did not fall with the last 90 days. Interventions included completing a CHA fall risk assessment at enrollment and every 6 months, monthly telephonic contact and fall assessment with members, and referral for in-home

physical therapy evaluation for members categorized as high-risk or those who had a fall within the last 30 days. For Complete Senior Care members, the percentage of members reporting no falls requiring medical intervention in the last 90 days increased by 2 percentage points from the baseline rate of 93% in 2014 to 95% in 2015. The percentage of members reporting no falls in the last 90 days increased by 4 percentage points from the baseline rate of 83% in 2014 to 87% in 2015. For Senior Health Partners members, the percentage of members reporting no falls requiring medical intervention in the last 90 days increased by 2 percentage points from a rate of 93% to 95%. The percentage of members reporting no falls in the last 90 days increased slightly by 1 percentage point.

Independence Care System: "Reducing Fall Risk and Injury"

The Plan has chosen "Reducing Fall Risk Injury", a topic which is highly relevant to the MLTC population. The PIP states that falls are associated with an increase in functional decline, morbidity, mortality, hospitalizations, and a corresponding increase in associated financial costs. It also states that the Plan has significantly higher monthly costs than other MLTC Plans. The Plan's rationale for selecting the topic is to reduce the rate of falls among the Plan's elderly membership in alignment with the Plan's mission to support adults and senior adults with physical disabilities and chronic conditions to live at home and participate fully in community life. The baseline 2014 data referenced Independence Care System (ICS) members (enrollees) were 94% falls free based on CHA documentation January through September 2014 versus statewide MLTC SAAM Score Card rate of 88% falls free in 2013. The 2014 baseline measured members "without medical intervention for falls." The PIP states that in 2015, the indicators were changed to the following: no falls within 90 days, no fall in the last 30 days but fell 31-90 days ago, one fall in the last 30 days and two or more falls in the last 30 days. The PIP states that the performance target was 85% of members being "falls free" at first assessment in 2015. Project indicators were any reported fall on the CHA for members answering "yes" to: no fall in the past 90 days, no falls in the last 30 days, but fell 31-90 days ago, one fall in the last 30 days, and two or more falls in the last 30 days. Members were offered a referral to the Plan's "Falls Risk Assessment Program" which included an in-home Fall Risk Assessment by a Physical Therapist. The PIP's rate for "no falls in the past 90 days" slightly improved by 0.6 percentage points from the baseline rate of 84.4% in 2014 to 85% in 2015. The PIP did not report baseline results for the other falls related indicators; there is no basis for comparison in interim year 2015.

Montefiore: "The Effectiveness of a Falls Prevention Program in the Elderly Population"

Falls are a major health concern among the vulnerable MLTC population. Approximately one out of every three adults aged 65 years and older falls each year, and among older adults, falls are the leading cause of fatal and non-fatal injuries both nationally and in New York City. Falls injuries include fractures and head trauma which result in decreased functional status. Additionally, falls among older adults can lead to a fear of falling which can result in a decrease in overall activity and loss of physical fitness which can increase the risk of future falls. The Montefiore Diamond Care MLTC Plan implemented a comprehensive falls prevention program (FPP) which seeks to assess the impact of this program across the member population. The program includes falls risk screening for all MLTC members and various interventions and services to address identified areas of need. The overall goal of the program was to prevent future falls through improvements in modifiable risk factors. The objective of the PIP was to increase the risk-adjusted percentage of MLTC members who reported no falls resulting in medical interventions in the past 90 days as reported on the CHA. The primary outcome variable was the risk-adjusted percentage of MLTC members who reported no falls resulting in medical intervention in the past 90 days as reported on the CHA. Intervention highlights included members being assessed for falls risk using the Missouri Alliance for Home Care tool (MAHC-10), referring members at risk to appropriate services and interventions and sending a mailing to members regarding falls risk prevention. Results showed demonstrated improvement compared to baseline. The percentage of members reporting no falls requiring medical intervention in the past 90 days increased by 8 percentage points from the baseline rate of 88% in 2014 to 96% in 2015.

PACE CNY

Approximately 30% of elderly adults over 65 years of age fall each year. Older adults who live in the community have a fall rate that varies from 28% to 35% for people over 65 years of age and increases from 32% to 42% for people 75 years of age and older. The topic is highly relevant to PACE CNY's membership of which 83% are female, with an average age of 82.2 years; over 46.9% of members are over the age of 85. The objective was to identify Plan members that had at least one fall and to use a multidisciplinary approach to reduce the risk of falling. The goal was a 15% reduction in the fall risk score for the PIP's population. The PIP also assessed if a decreased fall risk score resulted in an overall decrease in falls although a goal was not established for this indicator. The PIP's study population consisted of 100 members that

were equally assigned randomly to either the Study Group or the Control Group. Project indicators were the average falls risk score of participants in the control population and study population and falls per member per month (PMPM) for the total PACE CNY control population and study population. Interventions included scheduling participants with a high risk for falls for an appointment with the provider and pharmacist to review high risk medications and alternatives, as well as home evaluations conducted to assess surroundings and provide education regarding safety in the home and ensure participants with high risk scores have vision or hearing screening if not completed. This project demonstrated that multi-factorial interventions implemented based on the Omnicare Fall Risk Assessment Tool can reduce fall risk scores in an elderly PACE population. Although the actual objective of reducing the fall risk score by 15% was not achieved, the reduction of falls and risk scores in the intervention group was statistically significant. The overall risk scores and fall rates in the control group showed no significant change during the entire project. This suggests that interventions are effective in reducing the fall risk scores and may also contribute to reduction fall rates in an elderly community dwelling population.

Senior Whole Health: "Fall Management"

Senior Whole Health has chosen "Fall Management," a topic which is highly relevant to the MLTC population. The Plan's members are older than 65 years of age and include a low literacy, low income, ethnically diverse population that is medically and psycho-socially complex, disabled, chronically-ill or near the end of life. A population-based analysis from the Plan's CHA data shows that 42% of the Plan's membership fell during the 90-day period before the assessment was completed. Falls are associated with increasing the risk of mortality, morbidity, disability, frailty and increased costs. The goal of the project was to use Senior Whole Health resources to coach and educate members about the risk of falling, and strategies they can apply to mitigate that risk. Indicators for this PIP were members identified as being at low risk of falls, members identified as being at elevated risk of falls, members who received fall risk mitigation education, members at elevated risk of falling who received personal fall coaching, Durable Medical Equipment (DME) utilization, single falls in the last 90 days, and multiple falls in the last 90 days. Intervention highlights included providing educational materials to members, promoting physical activity and exercise programs to improve balance and strength, conducting in-person fall risk reduction coaching by nurse care managers for high-risk members, providing DME to members who qualified for it, and improving planning and environmental safety enhancement for high risk members. A review of care plans in the latter part of 2015 showed evidence that fall risk issues were being included in the Care Plans, but it is too soon to see a reduction in fall prevalence among the entire population. For this reason, Senior Whole Health requested, and has obtained approval, to continue the Fall Management PIP during 2016.

Pain Management

Pain is a significant health issue across MLTC populations. IPRO's review of CHA data for the January-June 2014 submission period indicated that 58% of members experienced some pain within the last three days of assessment and 42% of members described their pain as moderate. Uncontrolled pain was listed as a principal reason for hospitalization. Two plans conducted pain management PIPs in 2015.

Fidelis: "Reducing Pain for Managed Long Term Care (MLTC) Members

The project Reducing Pain for Managed Long Term Care (MLTC) Members, was conducted to decrease the incidence of pain through enhanced care planning in MLTC members in the Fidelis Care at Home (FCAH) and Medicaid Advantage Plus (MAP) lines of business who have recently reported frequent severe or excruciating pain on their 6 month Uniform Assessment System CHA reassessment. The interim 2014 Managed Long Term Care Report for the State of New York indicated that 7% of Fidelis Care members did experience severe or excruciating pain daily or on 1 to 2 of the last 3 days, which was one (1) percentage point above the statewide average. This Performance Improvement Project (PIP) studied the rationale that the experience of pain can be better managed and improved through in-depth assessment to determine root causes of uncontrolled pain, robust care plan development with implementation of targeted interventions, and continuous reassessment and care plan review with members. The project objectives were to (1) Reduce the occurrence of severe frequent pain for enrolled members; (2) Strengthen Plan care management activities through improved care planning and coordination surrounding pain management; and (3) Increase the percentage of members not experiencing severe or excruciating pain daily on the 2015 Managed Long Term Care Report for the State of New York. Project Indicators were the percentage of members with 6 month CHA reassessment performed and the percentage of members with uncontrolled pain reported on the 6 month CHA reassessment. Intervention highlights

included training care managers regarding expectations for monthly member contact, reassessment of pain, development of individualized care plan template, PCP contact and criteria for calling an ICT meeting as needed, and assuring implementation of interventions via monthly meetings to review care management records and study tools and protocols. Pain improvement, examined by comparing the initial baseline assessments and 6 month reassessment, performed on the study year of 2015, was found to be not sufficient a time period to bring about significant improvement in study outcome. Therefore, Fidelis Care has proposed to extend this PIP to 2016.

WellCare: “Using a Palliative Care Approach for the Management of Pain”

Pain can have profound effects on physical, mental and spiritual well-being. Patients with chronic pain have reductions in physical, psychological, and social well-being and have a health related quality of life that is lower than patients with most other medical conditions. Palliative Care is a disciplinary approach to symptom-control utilizing multidisciplinary approaches and a combination of therapies that include the emotional and physical aspects of pain symptom control and management. The premise of the project is to prove that a palliative multidisciplinary approach to pain management is superior to mono-therapies or no therapy. The objectives of the PIP were to show significant reduction in the number of WellCare members who reported pain, and the severity of responses for the following project indicators: those whose pain was not adequately controlled, whose therapeutic regimen was followed, but pain control not adequate or no therapeutic regimen followed, or no therapeutic regimen followed, report severe or excruciating pain. Interventions included telephonic care management, behavioral health and/or social work referral and face-to-face visits to provide pain management education, and care management training on how to address pain. Based on the results of the PIP, it is evident that the project, which focuses on demonstrating that a palliative multidiscipline approach to pain management is more effective to mono-therapies or no therapy in the MLTC population, is producing positive outcomes. Three out of the four indicators produced a favorable downward trend despite the fact that the 5% reduction goal was not met for each indicator.

Preventative Screenings: Eye, Ear and Dental Exams

Preventive screening exams are of critical importance and are equally important for younger as well as older individuals. CHA data show that 72% of MLTC members statewide have an annual eye exam, a result reflecting room for improvement. Moreover, 15 plans reported percentages below the statewide average. The CHA data indicated that the dental exam statewide average is 49%, with 10 plans reporting percentages below the average. It should be noted, though, that approximately 90% of the elderly exhibit some degree of oral disease, much of which is correctable or treatable if diagnosed at an early stage. This early-stage diagnosis is only possible with frequent dental exams. Education is crucial among the elderly, as they have the lowest dental utilization rate of any adult segment of the population. Healthy People 2020 has made it one of its goals to increase the proportion of hearing exams in the elderly. Hearing loss has been associated with social isolation, depression and stress. Seven plans conducted preventive screening PIPs in 2015.

ArchCare Community Life: “Improved Access to Dental Care through Enhanced Care Management”

Ninety percent of the elderly exhibit some form of oral disease. These diseases are often prevented or corrected if diagnosed at an early stage. ArchCare Community Life encounter data for dental services for dates of service January 1, 2014 to December 31, 2014, showed that 13.7% of ACL’s members had at least one (1) dental visit during the year. A satisfaction survey conducted in October of 2014 showed that 28% of ACL’s members reported their satisfaction level with their dentist as either “fair” or “poor.” The goals of the PIP were to increase utilization of the dental benefit by 5 percentage points over baseline to 18% by the end of 2015, and by another 5 percentage points to 23% by the end of 2016. Additionally, ACL sought to improve member satisfaction as evidenced by a reduction of the “poor” and “fair rating” of the dental provider observed in the 2014 member satisfaction survey from 28% to 24% the first year and to 20% the second year. The project indicator utilized by ACL was the percentage of ACL members who received at least one dental visit as determined from claims/encounter data provided by HealthPlex. Initial intervention highlights included care manager education on the importance of dental health, member education of dental health and appointment offerings via monthly calls, and newly enrolled member education on the dental benefits. Results of the PIP indicated a final rate of 14.3% in 2015, less than a 1 percentage point increase from baseline. As a result of these findings, ACL revised the goal to be 18% at the end of 2016 and implemented more active interventions: assistance with scheduling dental appointments, and distribution of brochures to members and care managers.

ArchCare Senior Life (ASL): "Dental Utilization Final Report 2015"

The objectives of the PIP were to (1) determine the frequency of general dental visits in 2014 and develop an educational campaign with HealthPlex to promote the importance of oral hygiene and to address common misconceptions, and to (2) conduct a participant survey to determine level of satisfaction with dental services offered, as well as to identify barriers to obtaining care. The project indicator utilized for the PIP was the percentage of members that utilized dental services by obtaining a general dental visit. The Plan's dental provider, HealthPlex, tracked and trended claims data and submitted the data to the Quality Assurance Department. Data were tracked monthly by claims paid, members serviced, number of claims and claims by procedure class. Intervention highlights included an in-service given to ASL staff at 3 PACE locations which addressed "good oral hygiene," an introductory letter and brochure about dental health and benefits given to all participants, and a dental event hosted by ASL PACE centers. HealthPlex tracked claims paid, members serviced, number of claims, and claims paid by procedure class for 2014 and 2015. Results for 2015 showed a significant increase in the number of members serviced and claims processed. The percentage of members utilizing dental services increased by 33 percentage points from the baseline rate of 6%. The PIP exceeded its goal of having at least 25% of members having a general dental visit during the measurement year.

ElderPlan – Homefirst (Partially Capitated): "Improvement in Prevention and Screening: Increasing the Rate of Annual Eye Exams"

Vision impairment in the elderly is a major public health concern. Reduced vision has been shown to result in increased risk of falling, resultant hip fractures, depression, and other age-related diseases. A review of the January-June 2014 MLTC report revealed that 63% of Homefirst's eligible population received an eye exam in the last year, which is 14% below the statewide average. The main objective of this PIP is to improve the rate of Homefirst members who received an eye exam to be at or above the NYS average of 72%. The project indicator for the PIP was the percentage of members who reported having an annual eye exam on the CHA. Interventions implemented included training provided to nurse assessors on the importance of preventive screenings and proper technique when asking members questions on screenings, and monthly calls by care management to educate members and coordinate eye exam visits. Additionally, claims encounter files were shared with nurse assessors so that they could be reviewed at the time of assessment. The percentage of members that reported having an annual eye exam on the CHA increased 15 percentage points to 78% between baseline and final measurement. The PIP exceeded the established goal rate (72%) which was set at the PIP-reported state-wide average for self-reported annual eye exams on the 2014 CHA

ElderPlan – MAP: "Improvement in Prevention and Screening: Increasing the Rate of Annual Eye Exams"

Vision impairment in the elderly is a major public health concern. Reduced vision has been shown to result in increased risk of falling, resultant hip fractures, depression, and other age-related diseases. A review of the January-June 2014 MLTC report revealed that 59% of the eligible population received an eye exam in the last year, which is 22% below the statewide average. The main objective of this PIP is to improve the rate of ElderPlan-MAP members who received an eye exam to be at or above the NYS average of 72%. The project indicator was the percentage of members who reported having an annual eye exam on the CHA. Interventions implemented included training provided to nurse assessors on the importance of preventive screenings and proper technique when asking members questions on screenings, and monthly calls by care management to educate members and coordinate eye exam visits. Additionally, claims encounter files were shared with nurse assessors so that they could be reviewed at the time of assessment. The percentage of members that reported having an annual eye exam on the CHA increased 12 percentage points to 71% between baseline and final measurement. The PIP final rate was 1 percentage point below the statewide average of 72%. The Plan did not meet the PIP goal of increasing screening rates to the statewide average of 72%, however, the rate increased by 18.5% from baseline.

GuildNet: "Promoting Dental, Vision and Audiology Exams"

To promote ongoing wellness, the GuildNet case management staff educates members and their caregivers on wellness topics throughout the year. Three of the capitated services authorized by GuildNet include Audiology, Vision and Dental which were targeted for improvement in utilization by GuildNet members in 2014 and 2015. GuildNet collected self-reported data from the CHA, the assessment that is completed a minimum of every 6 months for all members. The CHA includes questions regarding if the member has had an audiology exam in the past two years, as well as annual vision and dental exams within the past year. The goal of this performance improvement project was to improve, by ten (10) percent, the number of members who have reported that they have had a health screening for vision and dental within the past year and/or hearing within the past 2 years. Project indicators were the percentage of members with a CHA

reassessment during 2015 who reported a dental exam in the past year, percentage of members with a CHA reassessment during 2015 who reported an eye exam in the past year, and the percentage of members with a CHA reassessment during 2015 who reported a hearing exam in the past 2 years. Intervention highlights were encouraging members to obtain screenings for dental, vision, and hearing via quarterly newsletters and 2 health fairs in 2015, reaching out to contracted providers for home health care and Adult Day Health Care programs to foster collaboration and for providers to provide guidance to their staff to encourage and assist Plan members to access these health screenings, and educating Plan staff and providers on their roles in reinforcing education and assisting members to schedule and get eye, dental and hearing exams. Although the overall results did not meet the goal of 10% improvement in these health screenings, they did show some improvement in two of the indicators (eye and hearing exams) and no significant change in dental exams. GuildNet will continue to encourage its members and caregivers to access health screenings that pertain to all and also those that are specific to member's age, gender and diagnoses.

Hamaspik Choice: "Preventive Dental Screenings"

According to research published in 2001 by the Center for Disease Control and Prevention (CDC), oral health problems can severely impact an older person's quality of life by causing pain, difficulty eating, tooth loss, oral cancer, gum disease and other conditions that could result as side effects of the many prescription medications that are taken by a large percentage of the older population in order to control chronic conditions. The Hamaspik Choice's Quality Management committee ran two reports to determine the prevalence of preventive dental visits within the Hamaspik Choice member population. The first report was on member responses on the CHA to the questions of whether they had received an annual dental check-up in the past year and the second was a report on dental claims received by Hamaspik Choice for its members. The results of those reports – 37% and 17% respectively - indicated that far too few members were visiting the dentist for annual check-ups and that room for improvement was not only warranted, but necessary for the plan's membership to maintain their oral health and, by extension, their well-being in other areas as described in the CDC's 2001 report, referenced above. The PIP's objective was to increase the percentage of members who have at least one dental visit during the year by providing member education on the importance of preventive dental visits. The Plan selected the statewide average (49%) as the benchmark for improvement. The PIP's goals were to increase the percentage of members reporting a dental visit in the prior year on the CHA tool to 50% and to increase the percentage of members with a submitted dental claim to 30%. The project indicators were the proportion of the Plan's total membership for whom a dental claim was submitted during the project year and the proportion of the Plan's membership who indicated in their CHA that they had seen a dentist during the past year. Interventions were educational in-services for all nurse care managers on the importance of dental care in the elderly population, and monthly member education on the importance of dental health with encouragement to make an appointment with a dentist. The baseline measurement of the percentage of members for whom a dental claim was submitted increased from 17% in December 2014 to 25% in December 2015, with interim results of 21.6% in September. Overall CHA responses increased from 37% in December 2014 to 45% in December 2015 – with reassessments responses at 47%. Interim results in September 2015 were 44% on overall assessments and 47% on reassessments. Although the percentages fell slightly short of the original goals, they came close enough for the project to be considered a success.

Independent Living for Seniors (ElderOne): "New Enrollee Oral/Dental Care"

At ElderONE, all new participants are given an initial Oral/Dental exam by the participant's Primary Care Provider (PCP) during the initial History and Physical (H & P) review in the first 30 days of enrollment in the program. The purpose of this early screen is to identify oral/dental ailments at an early-stage in order to initiate treatment, triage referrals or otherwise prevent complications that might arise as a result of poor oral hygiene, side-effects of medications for chronic conditions, and others. Across New York State, the rate of dental utilization among the elderly is very low. In 2014, CHA data revealed that the statewide average dental exam rate was 49%. Poor oral health affects both quality of life and overall health status; individuals with poor dentition have limited food choices and can suffer from pain, respiratory infections, and other adverse medical events. At ElderONE, the mean age is 77.19 years (SD 10.39 years), making this population at risk for low dental utilization and its associated co-morbidities. The objective of the PIP was to identify and improve on the current process of monitoring and evaluation of delivery of oral/dental care to all new enrollees in 2015, as well as measure the annual dental visit rate across all existing plan members in 2015. Project indicators were: (1) percentage of new enrollees screened by a PCP during 2015, (2) percentage of new enrollees screened for immediate dental care following screening, (3) percentage of new enrollees referred for routine dental care following screening, (4) percentage of referred new enrollees who had kept their immediate appointment, (5) percentage of referred new

enrollees who kept their routine appointment, and (6) percentage of all existing participants who had an annual dental screen visit with a dentist within the past year. Interventions included development of compliance reports which provided both aggregate measure performance and the names of participants who were missing a dental screening, dental visit, or both, reminding providers to perform oral/dental screenings for new enrollees within the first 30 days of enrollment, and encouraging members to book dental visit appointments if they had not had one in 2015. For new enrollee dental screens, ElderONE set a best-practice target of 100% and achieved actual performance of 95%. Only 7 out of 140 new enrollees did not have a dental/ oral screen within 30 days of enrollment. For dental visits, ElderONE used the 2014 statewide average of 49% of participants with an annual dental visit as a benchmark target and achieved 61%. Although ElderONE performed significantly better than benchmark, there are still opportunities for improvement.

Total Senior Care: "Diabetic Eye Exams"

Diabetics are 40% more likely to suffer from glaucoma and this risk increases with age. As the pressure in the eye increases, the blood vessels carrying blood to the retina and optic nerve can be damaged. Diabetics are 60% more likely to develop cataracts and at a younger age. Total Senior Care (TSC) chose to focus their project on routine diabetic eye screenings to help screen and prevent the eye complications that can occur from diabetes. According to American Diabetes Association in 2014, 25% of Medicare beneficiaries have never had an eye exam or it has been 5 years or more since their last eye exam. Nearly $\frac{3}{4}$ of those individuals were diabetic. CHA data shows that 72% of MLTC members statewide have had an annual eye exam and that data correlates with Medicare's 25% who have not had an exam. At the end of December 2014, 41% of the enrolled participants were diabetic. The goal of the PIP was to prevent acute or chronic eye complications from progressing and to improve/maintain functionality & prevent deterioration through continuity and coordination of care. The PIP stated a goal of 90% of currently enrolled diabetic members to have had an annual eye exam. The indicator for the PIP was the percentage of currently enrolled diabetic members with an annual dilated, diabetic eye exam. Intervention highlights included participant education and assistance with scheduling appointments and transportation for participants, and determination if routine preventive dilated diabetic eye exams were up to date based on the members' individualized plan of care. Results indicated that diabetic annual eye exams increased by 46.5 percentage points to 100% between baseline and final measurement; the goal of 90% compliance was exceeded by 10 percentage points.

VillageCareMAX: "Preventive Screenings and Dental Exams"

Oral diseases such as periodontal problems, cavities, thrush infection and oral cancer can seriously threaten the health of older adults. If left unchecked, oral disease can lead to severe pain, loss of teeth and life-threatening health complications. Furthermore, recent studies suggest oral infections are associated with diabetes, heart disease and stroke. Preventive screenings and dental exams are the key to overall health and prevention of oral diseases. Evidence suggests that there is an increasing prevalence of oral diseases among the older population age 65 or older, specifically among those who are poor and may lack access to regular dental care. VillageCareMAX's membership is comprised of 80 percent adults aged 65 or older. Based on claims data, only 12.5 (n=343 members) percent of the members visited the dentist from January 2014 to June 2014. Project goals were to improve the dental utilization rate to 35% by November 30, 2015, achieve 90% completion for all members of dental assessments and interventions by Care Managers, and provide assistance in arranging for dental care. Project indicators were the percentage of members who had a dental exam, percentage of members who received education from their care managers about the importance of routine, preventive dental care, and percentage of members received assistance in arranging dental care. Intervention highlights included Care Managers conducting oral health assessments on all members due for CHA reassessments, educating members on the importance of oral health and good dental hygiene and dental coverage & available MLTC services, and Care Managers providing referrals for dental care and assistance in arranging for an appointment and transportation. Overall, the Oral Health Project was successful, as it demonstrated a significant improvement (51%) on dental utilization over a short period of time. An effective process of assessment and targeted interventions was adopted as part of the Care Management team's workflow. This will sustain the gains yielded from the project. Although notable improvement has been achieved, the project only made an impact on about 20% of VillageCareMAX's membership. More than 80% of its membership did not see a dentist. Through collaborative effort, the plan is confident to increase dental utilization among this group over time.

Section Seven: Summary/Overall Strengths and Opportunities

Strengths

PIPs - Overall

For advance directives (AD) PIPs, common goals were to increase the number of discussions regarding advance directives with membership and to increase the number of members for which advance directives had been executed and documented with the plans. Most plans faced barriers surrounding member language and cultural factors that may have prevented the member from completing an advance directive and some plans lacked consistency in the manner in which ADs were documented. Additionally, members who were cognitively impaired may not have had the capacity to make a decision about an AD and fill out AD forms. Most plans implemented interventions surrounding case management and member one-on-one education on the importance of advance directives. Other common interventions included enhancing plan EHR systems for AD documentation and the deployment of advance care planning tools to facilitate the discussion of ADs with plan membership. Five plans demonstrated improvement over their baseline rates for AD discussion and documentation at the plan.

Two plans conducted depression management PIPs, both of which showed improvement over baseline for depression screening. Both plans utilized the PHQ-9 depression screening tool as part of their interventions to ensure members were screened and subsequently followed up by a provider. One plan conducted a support group to help members cope with living with depression, which was a novel and unique intervention.

Three plans conducted emergency preparedness PIPs. The main goal for these PIPs was to ensure that members had the tools and education to help prepare them for an emergency situation. Common interventions were creating a personalized emergency preparedness plan for members and disseminating educational materials for members and caregivers. All plans who conducted emergency preparedness PIPs in 2015 showed improvement in the percentage of members being educated on the topic and having written documents accessible to them.

Twelve plans conducted falls PIPs in 2015. Most plans sought to improve the rate for the CHA no-falls rate. Barriers that many of these plans faced to prevent falls included the lack of physical activity among the membership, poor environmental conditions, and member recall bias and/or social desirability bias when reporting a fall on the CHA and to providers. Common interventions included development of a falls risk assessment tool to determine which members would be at risk for falls and providing members with education regarding falls risk. Most plans showed improvement in the percentage of members reporting no falls requiring medical intervention on the CHA.

Preventive screening PIPs were conducted by seven plans. The focus of these PIPs was to improve screening rates among members for dental, eye, and hearing care. Common interventions included staff and case manager education regarding screenings and their importance and the subsequent education of members on screenings. Additionally, plan staff members assisted members with setting up appointments with providers to obtain screenings. Most plans saw improvement on the CHA member self-reported screening rates at the end of the project.

Community Health Assessment (CHA)

Overall, PACE plans performed above the statewide average for most of the indicators in both reporting periods. The percentage of PACE members who experienced no severe daily pain was higher than members statewide in both reporting periods. In the second reporting period, PACE plans had higher rates than the rest of the state for all preventive care indicators (eye exams, dental exams, hearing exams, and influenza vaccines).

Slightly more MAP members received eye exams and influenza vaccines compared to members statewide. Additionally, a higher percentage of MAP members reported being bowel and urinary continent compared to members statewide in both 2015 reporting periods.

The percentage of FIDA members that reported no falls requiring medical intervention and no severe daily pain was higher than members statewide. This was true for both reporting periods in 2015. Additionally, in the first reporting

period, slightly more FIDA members reported having had a dental exam, while rates for all other preventive screenings were similar to statewide averages.

Opportunities

Pain management

Pain management PIPs were conducted by two plans in 2015. Interventions common to both plans were focused on staff training regarding pain management and care management (telephonic and face-to-face). Plans who conducted these PIPs did not see reduction in pain being reported by members on the CHA. Provider (PCPs, pain specialists, pharmacists) and case management interaction appeared to be minimal in these projects. Members would have likely benefitted from having those directly involved in the management of their pain coordinate with the care manager. Additionally, medication reconciliation interventions could have also been of benefit to members. Both plans have continued PIPs through 2016.

Falls

Plans who conducted Falls PIPs did not cite interventions which involved members' providers or PCPs. Providers are an important stakeholder in these initiatives due to the fact that they may not be aware that the member has fallen or that the member had a history of falls. Provider involvement in falls PIP interventions can include medication reconciliation/adjustment to mitigate the falls due to side effects of prescription, which has been cited as a common barrier among plans who conducted a falls PIP in 2015.

PIPs – General Recommendations

Across all PIP topics, interventions surrounded educating members via case management. It should be noted that interventions including educating members through mailings, especially those that are general and untailed, are passive and will likely have minimal impact on the outcome of the PIP. Face-to-face interactions between members and care managers are preferred, when possible, as they are likely to be more effective than passive interventions.

A common issue that plans faced during the course of conducting performance improvement projects was the lack of process measure development to inform intervention success. Each intervention should have one or more process measure associated with it so that plans can measure how successful or unsuccessful interventions are throughout the PIP. Process measures may reveal issues with one or more interventions and thus allow the plan to make necessary modifications to interventions and cut down (or scale up) on the use of resources. IPRO will emphasize the importance of process measure development and tracking for future PIPs.

Goals and target setting for performance indicators are an integral step in the PIP planning process. Many plans have set "weak" goals for their PIPs in 2015 and targets were not set individually for each performance indicator. Setting weak goals may be a detriment to the plan membership. For example, if a plan sets a goal to have an advance directive discussion with 85% of members, there are 15% of members which the plan may neglect to reach out to.

Community Health Assessment (CHA)

Since partially capitated plans make up a large proportion of the statewide average, any differences in rates for partially capitated plans were negligible compared to the statewide average across all indicators.

The percentage of PACE members reporting urinary continence, bowel continence, and no feelings of anxiety was lower than the statewide average in both reporting periods. This presents an opportunity for plans to coordinate with the member's care team and/or caregivers to explore the factors that may contribute to fewer members being urinary and bowel continent.

Four out of the six activities of daily living indicators were lower among MAP plans compared to the rest of the state. Two of these indicators were slightly higher than the statewide averages: ambulation (49.3% vs. 48.3%) and bathing (12.6% vs. 11.5%). Fewer MAP members experienced no pain and no falls requiring medical intervention than members statewide. Plans may wish to consider conducting PIPs that focus on falls prevention or pain management to increase the number of members who report having no severe daily pain and/or no falls requiring medical intervention.

Compared to members statewide, fewer FIDA members were able to perform the six ADLs in both reporting periods of 2015. Additionally, a lower percentage of FIDA members reported being urinary and bowel continent when compared to the rest of the state. Although a slight improvement from the previous reporting period, all preventive screenings indicators were lower for FIDA members, with the exception of the influenza vaccine, in which 78.6% of FIDA members reported having versus 76.7% of members statewide. Plans may wish to consider conducting PIPs that aim to increase quality of life and the number of members being screened for eye exams, hearing exams, dental exams, and flu vaccine.