PIP Topics, Aims, and Interventions Report for the Family Care (FC), Family Care Partnership (FCP), and PACE Programs

CCI – Caring for the Caregivers			
Point of Contact	**PIP Topic**	**PIP Aim(s)**	**PIP Interventions**
Theresa Baker Theresa.Baker@communitycareinc.org Halanna Lathon Halanna.Lathon@communitycareinc.org Sadie Beacham Sadie.Beacham@communitycareinc.org Kelly Mitchell Kelly.Mitchell@communitycareinc.org	Caregiver Strain	Can a continued educational campaign targeting paid SDS caregivers and unpaid preferred caregivers in the Family Care Program identified as mild to moderate or moderate to high risk of caregiver burnout reduce their risk of burnout from 11.8% to 6% between January 1, 2026, and December 31, 2026?	- Implement a targeted caregiver educational campaign for paid SDS caregivers and preferred caregivers in the Family Care Program who are identified as being at mild to moderate or moderate to high risk for burnout. - Education will include a resource guide that discusses stress management, self-care, resilience skills, available supports, and how to access respite and community resources. - Delivery methods will include one-on-one conversations during care planning or mail delivery of written/translated materials.
CCI – Taking Control of Your A1c: "Less Than 8, is Great!"			
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Theresa Baker Theresa.Baker@communitycareinc.org Halanna Lathon Halanna.Lathon@communitycareinc.org Sadie Beacham Sadie.Beacham@communitycareinc.org Kelly Mitchell Kelly.Mitchell@communitycareinc.org	Diabetic Care	Can implementing diabetic management goals and interventions increase the percentage of members actively enrolled in Family Care-Waukesha and Kenosha, Family Care Partnership and PACE, aged 18-75 years, who have a diagnosis of Type 1 or 2 diabetes, with a controlled A1c less than 8%, from 33% to 40% between January 1, 2026, and December 31, 2026?	Staff will provide education about the importance of managing A1cs and how to take steps to lower A1cs. Staff can direct members to various websites that provide education around diabetic management. Additionally, Staff will provide resources or assist with access to testing and retesting. Explore DME needs or additional technology to support self-testing or monitoring devices. Refer to Primary Care to order labs. Staff will follow the CPG for Diabetes Type 1 and 2. The Diabetic Management goal will be operationalized and can be used to assist in monitoring not just the A1c but any diabetic goal the member may have.
Humana – Inclusa/iCare – Improving Glycemic and Blood Pressure Control in Members with Diabetes and Hypertension			
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Holly Miller Holly.Miller@inclusa.org Meghan Hyland mhyland@icarehealthplan.org Tina Schroeder CSchroeder12@inclusa.com	Hypertension and Diabetes	**Inclusa (FC):** Through the implementation of targeted education to FC members with Type 1 Diabetes and Hypertension who are not receiving hospice or terminal care, will the percentage of FC members meeting those criteria with a last recorded blood pressure of >130/80 AND a last laboratory test for Hgb A1c > 7%, and are continuously enrolled during the project timeframe, decrease from 28.9% to 27.9% during the project timeframe of January 1, 2026 – December 31, 2026? **iCare (FCP):** Through the implementation of targeted education to FCP members with Type 1 Diabetes and Hypertension who are not receiving hospice or terminal care, will the percentage of FCP members meeting those criteria with a last recorded blood pressure of >130/80 AND a last laboratory test for Hgb A1c > 7%, and are continuously enrolled during the project timeframe, decrease from 29.5% to 28.5% during the project timeframe of January 1, 2026 – December 31, 2026?	**FC & FCP Strategy:** Integrated Care Management and Education Integrated Care Management and Education is a targeted initiative designed to help members with Type 1 diabetes lower their blood pressure and hemoglobin A1c through personalized, evidence-based interventions. This strategy leverages a multidisciplinary care team—including Field Care Manager Nurses, and Nurse Managers to deliver coordinated outreach, education, and ongoing support. **What Will Be Done:** Proactive Identification: Members with both elevated hemoglobin A1c (>7) and high blood pressure (>130/80) will be flagged using clinical data analytics and shared with care management teams. Personalized Outreach: Care Coaches and Field Care Manager Nurses will conduct direct outreach via phone, secure messaging, and in-person visits to engage identified members. Embed conversations about the management of comorbidities of Hypertension and Type 1 Diabetes into monthly member contacts, at quarterly in-person visits and at plan review reassessments. This will provide multiple opportunities for repeated education and resource sharing by care management IDT, and the repeated use of the motivational interviewing technique with members. Clinical Assessment: A thorough review of medication regimens, self-care behaviors, barriers to adherence, and social determinants of health will be conducted for each participant. Education and Goal Setting: Field Care Manager Nurses will provide tailored education on nutrition, medication management, physical activity, and blood pressure monitoring. Members will collaborate with their IDT to set realistic, measurable goals.

			Ongoing Support and Follow-up: The care team will monitor progress regularly, provide encouragement, troubleshoot challenges, and adjust care plans as needed. Follow-up will include scheduled check-ins on progress. Resource Connection: Members will be connected to community resources, digital health tools, and support groups as appropriate to reinforce healthy behaviors and address non-clinical barriers. **Who Will Do It:** Field Care Manager Nurses will lead outreach, education, and coaching. Care Coaches will assist with resource connections. **How It Will Be Implemented:** The program will launch with a data-driven identification of target members. Monthly data reviews of member progress will occur by the Senior Process Improvement Professional and coordinated interventions to support IDT and members will occur. Outcomes – including improvements in blood pressure and A1c – will be tracked and reported monthly to drive accountability and continuous improvement.
Humana – Inclusa/iCare – Improving Member Completion Rates of Advanced Directives (AD)			
Point of Contact	**PIP Topic**	**PIP Aim(s)**	**PIP Interventions**
Holly Miller Holly.Miller@inclusa.org Meghan Hyland mhyland@icarehealthplan.org Tina Schroeder CSchroeder12@inclusa.com	Advance Care Planning	**Inclusa (FC):** Through the provision of AD education to members without ADs in the entire FC population having AD information on file, during routine care management January 1, 2026 through December 31, 2026, using culturally and linguistically appropriate materials and motivational interviewing, will the	Specific interventions that will be used to drive improvement: **Strategy 1 (FC & FCP):** What: AD education to members who do not have completed ADs during routine care management through the use of culturally and linguistically appropriate materials. How: Care management interdisciplinary team (IDT) will be provided with a standardized script to introduce and explain the importance of ADs during every eligible member interaction. Resources will be created and available to Care management

		percentage of FC members having completed ADs increase from 25.3% FC as of October 1, 2025 (baseline), to 26.3% (repeat) by December 31, 2026? **iCare (FCP):** Through the provision of AD education to members without ADs in the entire FCP population having AD information on file, during routine care management January 1, 2026 through December 31, 2026, using culturally and linguistically appropriate materials and motivational interviewing, will the percentage of FCP members having completed ADs increase from 39.2% as of October 1, 2025 (baseline), to 40.2% (repeat) by December 31, 2026?	IDT for member education and distribution in easy-to-understand resources in members' preferred languages. Care management IDT will be required to document the AD education, resource sharing, and interventions implemented in their respective systems to support members in completing their ADs. **Strategy 2 (FC & FCP):** What: Care Management staff will embed conversations about ADs into monthly member contacts, at quarterly in-person visits, and at plan review reassessments. This will provide multiple opportunities for repeated education and resource sharing by care management IDT, and the repeated use of the motivational interviewing technique with members. How: Using motivational interviewing techniques, which Care Management staff will be required to complete a training for to reinforce their skillsets. These conversations about ADs will provide multiple opportunities for repeated education and resource sharing by care management IDT, and the repeated use of the motivational interviewing technique with members.
LCI – Breaking Barriers to Immunity: Increasing Pneumococcal Vaccinations Among Physically Disabled Seniors			
Point of Contact	**PIP Topic**	**PIP Aim(s)**	**PIP Interventions**
Katherine Schultz Katherine.Schultz@lakelandcareinc.com Christy Schmidt Christina.Schmidt@LakelandCareInc.com	Immunizations	Does targeted member resources and education by interdisciplinary team (IDT) staff on the importance of Pneumococcal vaccination for members in the Physically Disabled (PD) Target Group (TG) who are age 50 and over increase their vaccination rate from 62.7% to 67.7% from 01/01/2026 through 12/31/2026?	**Strategy: Health Equity Immunization Outreach Program** This intervention will be delivered as a comprehensive education and outreach campaign designed to address barriers such as misinformation, unclear guidelines, and access challenges. To accomplish this, Registered Nurse Care Managers (RNCMs) will participate in an online training session that will be available all of January 2026 to strengthen their ability to educate members on the importance of pneumococcal vaccination and proactively schedule appointments if

			requested. This training will also be required and available for newly hired RNCMs prior to assuming their caseloads. Each RNCM will have access to a standardized outreach toolkit that includes multilingual, culturally tailored educational materials and documentation guides. After completing the training, RNCMs will initiate outreach by providing member-specific education during face-to-face care management visits. During these interactions, RNCMs utilize member-centered motivational interviewing strategies to review updated CDC guidelines recommending pneumococcal vaccination for all adults aged 50 and older, explain the benefits and safety of the vaccine, and assist members in scheduling vaccination appointments if the member requests this. Outreach will occur at least once during the project period (1/1/26-12/31/26). All materials will be available in multiple languages and adapted for cultural relevance to foster trust and comprehension. RNCMs will document all outreach activities and member vaccination status changes in the Electronic Member Record (EMR) to ensure accountability and enable ongoing evaluation. This approach combines proactive education, culturally competent engagement, and logistical support to reduce disparities and improve pneumococcal vaccination rates among PD target group members aged 50 and over.
LCI – Screening for Connection: A Quality Improvement Approach to Loneliness			
Point of Contact	**PIP Topic**	**PIP Aim(s)**	**PIP Interventions**
Katherine Schultz Katherine.Schultz@lakelandcareinc.com Christy Schmidt Christina.Schmidt@LakelandCareInc.com	Social Needs	Does targeted cultural and linguistically appropriate education by interdisciplinary team (IDT) staff on the impact of loneliness on physical health and the importance of screening for loneliness for	**Strategy: Social Connection Outreach Strategy** This intervention will be implemented as an education campaign to increase member participation in loneliness screening. To accomplish this, Care Managers (CMs) will participate in an online training session that will be available all of January 2026 to

		members increase FC members' willingness to self-disclose their loneliness status via a standardized screening tool at least once annually from 61.5% to 66.5% from 1/1/2026 through 12/31/2026?	enhance their ability to identify signs of loneliness, initiate sensitive discussions, and encourage members to self-report their loneliness status using a standardized screening tool. This training will also be required and available for newly hired CMs to complete prior to taking on their caseloads. Each CM will also have access to a standardized outreach toolkit that includes multilingual educational materials and documentation guides. After the CM has completed this training, outreach will then take place. This will consist of CMs providing education to members and/or their legal representatives on the risks associated with loneliness during a face-to-face visit with the member utilizing member-centered motivational interviewing strategies that are core elements of the intervention training to staff. During this visit, CMs will also request that the member complete a standardized screening tool for loneliness minimally at each MCP review if the loneliness screen has not been completed within the past year. All materials and information provided will be available in multiple languages and adapted for cultural relevance. CMs will document outreach activities and member responses to the standardized screening tool in the EMR to ensure accountability and enable ongoing evaluation. This approach combines proactive education and culturally competent engagement to foster trust and encourage members' self-disclosure of loneliness.
MCW – Enhancing Quality of Life for FC/FCP Members			
Point of Contact	**PIP Topic**	**PIP Aim(s)**	**PIP Interventions**
Kelsey Fredricksen kelsey.fredricksen@mychoicefamilycare.com Mary Wright Mary.Wright@mychoicewi.org	Social Needs	Will implementation of a wellness guide increase the percentage of FC/FCP members - in the PD Target Group, without a legal decision maker, and	**Strategy: Implementation of a Wellness Guide** MCW will implement a wellness guide as a targeted and measurable intervention designed to enhance quality of life for FC/FCP members. This strategy involves

		continuously enrolled from their May Assessment to November Assessment - reporting their quality of life as good, very good, or excellent from 69.2% (baseline MP: May 1, 2025 - November 30, 2025) to 76.5% (results MP: May 1, 2026 - November 30, 2026).	both the development of a comprehensive guide and the training of care management staff on how to introduce and utilize the guide with members. The Non-Clinical PIP Team will collaboratively design the guide and staff training, actively incorporating feedback from the Member Advisory Committee to ensure the intervention is relevant and responsive to member needs. The wellness guide will emphasize the "circle of control," empowering members to focus on aspects of life they can directly influence, such as daily routines, healthy habits, mindfulness practices, and social engagement. By fostering autonomy and dignity, the strategy aims to reduce feelings of helplessness, promote emotional well-being, and support member choice, ultimately improving self-reported quality of life. All care management staff will have access to the guide and will be encouraged to share it with any FC/FCP member who may benefit. While the guide will be designed for broad applicability across all members, staff training will highlight insights and implementation strategies tailored to the PD target group to ensure effective and personalized support. The wellness guide strategy is inclusive, adaptable, and directly aligned with the PIP aim of increasing the percentage of FC/FCP members reporting good, very good, or excellent quality of life. By equipping care team staff with practical tools and training, MCW will drive measurable improvements in member self-reported quality of life.
MCW – Vaccination Hesitancy and Trauma Informed Care			
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Lindsey Marschke Lindsey.marschke@molinahealthcare.com Kelsey Fredricksen	Immunizations	MCW will increase the percentage of continuously enrolled FC and FCP members who	**Strategy: Staff Training** FC and FCP staff will complete *Influenza Vaccination: Hesitancy and Trauma-Informed Care* training in May/June 2026.

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