Audit Review Period:	

Issue of non-compliance:	IDT remaining alert to pertinent input

Scope:	• The scope of this Impact Analysis is limited to 50% of the participants enrolled during the audit review period who were not included in the provision of services sample selection. • The auditor will select the participants to be reviewed and enter their identifying information on the Participant Impact tab.

Instructions:	• Review only the participant medical records selected by the auditor. The selected participants are identified in the Participant Impact tab. • Review documentation during the audit review period identified in this tab (Instructions). • Determine if the IDT did not remain alert to any pertinent input from other team members, participants, and caregivers. • Respond to the questions in the participant impact tab. • After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the changes in the RCA tab.

Impact Analysis Due Date:	

Date Identified (MM/DD/YY) (Completed By The CMS Audit Lead)	Brief Description Of Issue (Completed By The CMS Audit Lead)	Condition Language (Completed By The CMS Audit Lead)

Detailed Description of the Issue (Explain what happened) (Remaining fields to be Completed by PACE Organization)	Root Cause Analysis for the Issue (Explain why it happened)	Methodology - Describe the process that was undertaken to determine the # of individuals (e.g. participants) impacted	# of Individuals Impacted	Action Taken to Resolve System/ Operational Issues

Date System/ Operational Remediation Initiated (MM/DD/YY)	Date System/ Operational Remediation Completed (MM/DD/YY)	Actions Taken to Resolve Negatively Impacted Individuals Including Outreach Description and Status	Date Individual Outreach and Remediation Initiated (MM/DD/YY)	Date Individual Outreach and Remediation Completed (MM/DD/YY)

Participant First Name	Participant Last Name	Participant ID	Date of Enrollment MM/DD/YYYY	Date of Disenrollment MM/DD/YYYY	Reason for Disenrollment

During the audit review period, did any PO employee, contracted employee, or contractor fail to communicate pertinent information regarding the participant's medical, functional, or psychosocial condition to members of the IDT? (Yes/No) If NO, the PO may enter NA in all remaining fields.	Please provide a brief description of the pertinent information that was not communicated to the appropriate IDT member(s). (This includes information that was not communicated at all, and delayed communication of pertinent information)	When did someone at the PO first become aware of the issue (it was first discovered or documented)? MM/DD/YYYY

Who reported the issue initially (participant, caregiver, SW, PCA, SNF staff, etc.)?	Which staff member received the initial report (PCP, NP, RN, SW, OT, PT, Dietitian, HCC, RT, PCA, Driver, Center Manager)?	Where was the initial report documented (progress notes, on-call log, etc.)?

Was the information communicated to the appropriate members of the IDT at some point (even if delayed)? (Yes/No)	Date the information was communicated to the appropriate members of the IDT. MM/DD/YYYY Enter NA if the information was never communicated to the appropriate IDT members.	Did the communication issue cause a delay in or failure to: assess the participant, provide necessary care and/or services, provide access to emergency care, etc.? (Yes/No)	If the communication issue caused a delay in or failure to: assess the participant, provide necessary care and/or services, provide access to emergency care, etc., please describe the care and/or services that were not provided or were delayed. Enter NA if Not Applicable

Were the services delayed or not provided? Enter Delayed or Not Provided Enter NA if Not Applicable	If delayed, what date did the participant receive the appropriate care and/or services. Enter Date Enter Not Provided if the services were never provided. Enter NA if Not Applicable	What documentation or evidence does the PO have to demonstrate that the services were provided? (i.e., progress note in the medical record, record from a specialist, etc.).

If the participant experienced negative outcomes, did they occur, in some part, as a result of the failure to provide or a delay in the provision of care and/or services? (Yes/No)	If yes, describe the negative outcomes. Enter NA if Not Applicable

Optional: Please note, you do not have to complete this column. If there are any mitigating factors that you would like CMS to consider related to a specific participant, please enter the information in this column.