At the Intersection of Care Transitions, Care Plan Goal Development, and Consistency of Outcomes Documentation

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Intersection of Care Transitions and Care Planning with members

BlueCross BlueShield Minnesota
UCare
MEDICA®
South Country Health Alliance
HealthPartners
PrimeWest Health
Managed Care Organization Collaboration

- Overview of streamlining processes:
  - Collaborative Care Plan
  - Care Plan Development and Goal Writing
  - Transitions Management
  - Audits
- Case Studies
- Summary
Why Are We Here?

• Minnesota Health Plans history of collaboration
  – Review CMS and DHS requirements
  – Consistent interpretation and training when possible

• Managing members throughout transition process

• It’s not just about filling out forms!
Why the Focus on Transition Management?

• CMS focus

• Nationwide efforts to reduce readmissions
  – Care Transitions Program – Dr. Eric Coleman
  – National Transitions of Care Coalition

• RARE Campaign
A Collaborative Approach to Care Plan Development
DHS Care Plan Requirements

• Comprehensive Care Plan development is based on available information including issues or needs identified by risk and comprehensive assessments, medical records and/or previous utilization to the extent they are available, and member and/or family input.

• Incorporate interdisciplinary, holistic and preventative focus
DHS Care Plan Requirements (Part 1)

- Advance directive planning
- Unique primary, acute, long-term care, mental health, and social service needs of each member with appropriate coordination and communication across all providers

- Requirements are incorporated into care plan and;
- Incorporated into DHS audit protocol
- Health Plans and DHS work together for consistency and best practice recommendations
Why a Collaborative Care Plan?

- Care coordination/case management delegates asked for one care plan that all health plans would accept for audit purposes

- The Collaborative Care Plan was developed to:
  - Promote consistency
  - Ensure care plan regulatory requirements were met
  - Address other assessment items not on the LTCC
  - Allow for smoother case transitions
  - Audit consistency
Health Plan Workgroup Collaborative Care Plan History

- Participating Health Plans: Blue Plus, Health Partners, Itasca Medical Care (IM Care), Medica, Metropolitan Health Plan (MHP), PrimeWest Health, South Country Health Alliance, UCare
- Began working together in February, 2007
- Developed the Collaborative Care Plan and provided a statewide video conference training in 2009
- 2013 Updates to the Collaborative Care Plan and Instructions statewide videoconference
Care Plan Differences Between Health Plans

- Some health plans use different care plan documents, but required elements are the same:
  - IMCare
  - South Country Health Alliance
  - Prime West
  - HealthPartners
Care Plan Development

• Where to find information for goal writing
• Goal writing
• Developing member-centered goals
• S.M.A.R.T. goals
• Care Plan as a “Living document”
Where to Find Information for Goal Writing (part 1)

LTCC:

• **Best practice recommendation**: document additional information in comment sections on LTCC to use in goal writing
• Caregiver supports/social resources
• Health assessment
  – Multiple diagnoses
  – Medication management
• Medical utilization – frequent visits to physician/clinic
Where to Find Information for Goal Writing (part 2)

LTCC:

- Nutrition - Weight loss/gain
- Alcohol/tobacco/substance use
- Emotional/mental health
- Self preservation/safety
- Environmental assessment; abuse and neglect screen
Where to Find Information for Goal Writing (part 3)

Member Input:
- Member’s concerns
- Health conditions that may be causing difficulty
- Mental health needs
- Preventative care
Collaborative Care Plan:

- Advanced directives
- Health prevention/chronic conditions
  - Pain screening
  - Medication compliance
  - Frequent visits to ER
Goal Writing

- What is a goal? A desired result
- What does the member want to accomplish?
- DHS Audit protocol requirement
Developing Member Centered Goals

- **SMART** goal writing model
  - Specific
  - Measurable
  - Attainable
  - Relevant
  - Time-Bound
<table>
<thead>
<tr>
<th>Not SMART Goal</th>
<th>SMART Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member wants to lose weight (not specific)</td>
<td>Member wants to lose 15 pounds within the next 6 months</td>
</tr>
<tr>
<td>Member wants help with his diabetes (not specific, not measurable)</td>
<td>Member’s blood sugars will remain stable over the next 12 months</td>
</tr>
<tr>
<td>Member will stay living in her home (not specific)</td>
<td>1. Member will be compliant with high blood pressure medication</td>
</tr>
<tr>
<td></td>
<td>2. Member will be free from falls for the next year</td>
</tr>
<tr>
<td></td>
<td>3. Member will eat a minimum of 1 healthy meal/day</td>
</tr>
</tbody>
</table>
Care Plan as a “Living Document”

- Update care plan as required by health plan
- Audit protocol requirements (common audit error)
  - Monitor & document progress- how is member doing at achieving their goals?
  - Record goal outcomes
    - Did the member meet the goal?
    - Will the goal be discontinued, modified or carried forward?
- Transitions of Care—use in your work with member throughout transitions
  - Want to have the most updated information to share with the receiving facility at the time of a transition
  - Update the care plan following the transition
A Collaborative Approach to Transition Management
Goal:
• To reduce hospital readmissions by improving member support for the transition from hospital to home or a care setting for MSHO, MSC+ and SNBC members.
Data: Collaborative data set for HEDIS®
  Plan All-Cause Readmission (PCR) Rate (30-day)

Key Interventions:
• Improve Transition of Care (TOC) Log
• Train care coordinators
• Annual audits
Manage Discharge from One Setting to Another

Transition: Movement of a member from one care setting to another as the member’s health status changes.

Transition Goals:

• Improve communication with Interdisciplinary Care Team (ICT) and others involved in the discharge process
• Ensure appropriate and needed services are in place at discharge
• Care plan accurately reflects member’s needs and goals.
Transition of Care Log
Four Pillars for Optimal Transition:

*This section should be completed only when the member discharges TO their usual care setting.*

- Timely follow-up visit
- Medication self-management
- Knowledge of red flags
- Use of personal health record
Purpose of Transition Management/Documentation:

• Support members through transitions
• Identify problems that could cause transitions
• Prevent or reduce unplanned or avoidable transitions.
• Meet regulatory requirements for managing care transitions.
Resources:

- TOC Log
- TOC Log Instructions
- Fax cover sheet - Care Transition - Provider Notification
- TOC Toolkit
- TOC Log Scenarios

Tools are available on the Stratis Health web site - PIPs
2013 TOC Log Audit: Lessons Learned

• Lack of timely notification of discharge from hospital providers.

• CCs often are not aware that a member was admitted or discharged and when it occurred until after the discharge.

• It is difficult to connect with hospital discharge planners.

• TOC Log – section on Four Pillars of Optimal Care only needs to be completed when member is discharged to their usual care setting.
Questions and Answers
A Collaborative Approach to Care Plan Audits

- **Minnesota Department of Human Services** Managed Care (MSHO and MSC+) Elderly Waiver Care Planning Audit *(as required under 7.1.4.D., 7.8.3, and 9.3.9 of the 2013 MSHO/MSC+ contract)* 2013 Audit Protocol *(Referred to as the “Care Plan Data Collection Guide” in the DHS Triennial Compliance Assessment (TCA) conducted by the Minnesota Department of Health)*

- **Goal**: To facilitate an interdisciplinary, holistic, and preventive approach to determine and meet the health care needs and supportive services needs of members
Purpose of Collaboration Between DHS and Managed Care Organizations

- Review CMS and DHS requirements
- Consistent interpretation of care plan audit requirements
- Promote consistency of the audit process and outcomes between MCOs
- Ensure care plan regulatory requirements were met
Collaborative Process Between DHS and Managed Care Organizations

- Meet monthly at DHS as a group with representation from DHS and all MCOs at the table
- Review the entire care plan audit protocol with current contract requirements
- Review process is about a 3 month process
- DHS is very open to changing verbiage for clarity
Another Collaborative Process Between DHS and Managed Care Organizations

• Final version is accepted by the group
• DHS provides the final version to the MCOs
• MCOs provide the education to the Case Managers
Areas Identified as Potential Areas for Improvement

• There was not consistent auditing among MCOs
• There was not consistent interpretation between contract requirements and actual audit practice
• MCOs had various ways of reporting audit outcomes
• Difficult for DHS to report outcomes measures to CMS due to inconsistent reporting of outcomes
Positive Outcomes as a Result of this Collaborative Partnership

• Input as a collaborative team has lead to consistent, reliable outcomes to measure contract compliance
• Consistent measurable outcomes for DHS to use for reporting purposes to CMS
• A close collaborative partnership between MCOS and DHS
Collaboration on Case Studies
Feeling Stuck?
Small Groups

• 7-10 minutes to create interventions and outcomes based on the MSHO patient story
• Assign a note taker and speaker
• Come back as a larger group to share interventions with the remaining
Closing Statements

• Collaboration between MCOs and DHS
• Each health plan may have different requirements, but there is communication between all of the plans
• Care plan, transitions, audits...
Thank you, Care Coordinators!!