Best Practice Care Coordination Conference

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

Managed Care Organization Collaboration

- Overview of streamlining processes:
  - Collaborative Care Plan
  - Care Plan Development and Goal Writing
  - Transitions Management
  - Audits
- Case Studies
- Summary

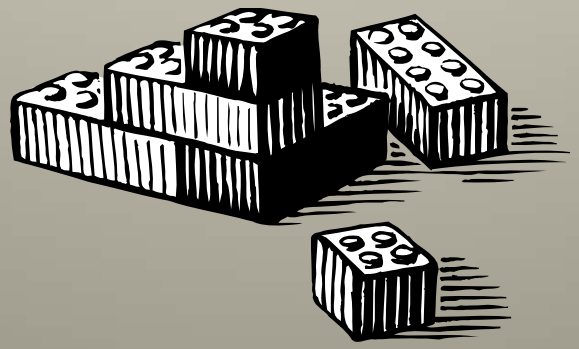
Why Are We Here?

- 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)

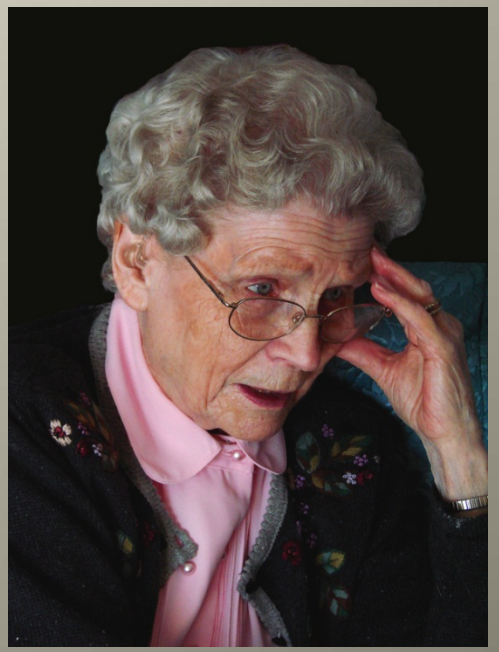
LTCC:

- 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



Where to Find Information for Goal Writing (part 4)

Collaborative Care Plan:

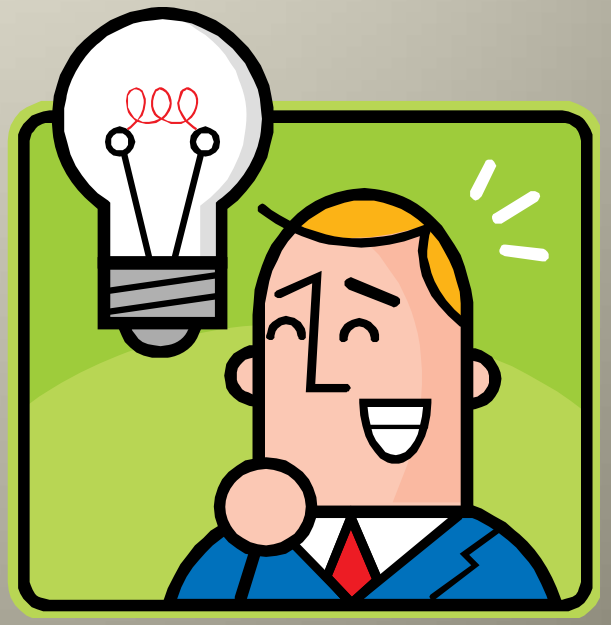
- Advanced directives
- Health prevention/chronic conditions
  - Pain screening
  - Medication compliance
  - Frequent visits to ER

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
  - **S**pecific
  - **M**easurable
  - **A**ttainable
  - **R**elevant
  - **T**ime-Bound



Not SMART vs. SMART goals

Not SMART Goal	SMART Goal
Member wants to lose weight (not specific)	Member wants to lose 15 pounds within the next 6 months
Member wants help with his diabetes (not specific, not measurable)	Member's blood sugars will remain stable over the next 12 months
Member will stay living in her home (not specific)	1. Member will be compliant with high blood pressure medication 2. Member will be free from falls for the next year 3. Member will eat a minimum of 1 healthy meal/day

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

BlueCross BlueShield Minnesota

MEDICA®

MHP® METROPOLITAN HEALTH PLAN

UCare

2012 CMS QIP / 2013 DHS PIP: Improving Transition Post-hospitalization

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.

CarePlan 2012 CMS QIP/2013 DHS PIP: Improving Transitions Post-hospitalization

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

TRANSITION OF CARE (TOC) LOG

Communication tasks to be completed **within 1 business day of notification** include notify member's PCP; share care plan; inform member/responsible party about care transition process and support person, communicate with member/responsible party about changes to member's health status and care plan. (Effective: 4/15/14)

Member Name:			**MCO Name:**
PMI #:	**Product:**		**MCO/Health Plan Member ID#:**
Care Management Contact:			**Agency/County/Care System:**

Transition Communication Actions from Care Management Contact

Notification Date:	Transition Date:	Transition From: (Type of care setting)	Transition To: (Type of care setting)
		Is this the member's usual care setting? ☐ Yes ☐ No	Is this the member's usual care setting? ☐ Yes ☐ No

Transition Type: ☐ Planned ☐ Unplanned

Transition Description:

Date completed: Notified PCP of transition via ☐ Fax ☐ Phone ☐ EMR (OR) ☐ Member's PCP was the Admitting Physician

Date completed: Shared care plan with receiving setting (Review current services).
Date completed: Communicated with member/responsible party about changes to the member's health status and plan of care.
Date completed: Communicated with member/responsible party about the care transition process.
Date completed: Educated member/responsible party about transitions and how to prevent unplanned transitions/readmissions.

Comments:

Four Pillars for Optimal Transition:

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

Check "Yes" - if the member, family member and/or SNF/facility staff manages the following:

☐ Yes ☐ No Does the member have a follow-up appointment scheduled with primary care or specialist?
☐ Yes ☐ No Can the member manage their medications or is there a system in place to manage medications *(e.g. home care set-up)*?
☐ Yes ☐ No Can the member verbalize warning signs and symptoms to watch for and how to respond?
☐ Yes ☐ No Does the member use a Personal Health Care Record? *Check "Yes" if visit summary, discharge summary, and/or healthcare summary are being used as a PHR.*

Comments:

As a result of this transition discussion:

☐ Yes ☐ No ☐ N/A Have you updated the member's care plan? *Check "N/A" if SNF/facility staff, is responsible for the care plan.*

If No, explain:

TOC Log: Discharge Planning

Four Pillars for Optimal Transition:

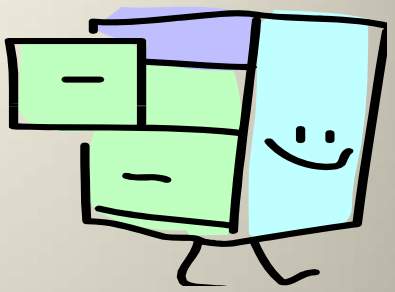
This section should be completed only when the member discharges TO their usual care setting.

- **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!!

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