HealthPartners Model of Care

Chart Review Findings

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Introductions

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Model of Care Audit Protocol

CMS = Clinical Focus

DHS = Person-Centered Focus

Model of Care Chart Review Findings

2.2.2. Did the sponsor develop a comprehensive ICP designed to address needs identified in the HRA, consistent with the MOC?

2.2.3. Did the ICP include measurable outcomes in accordance with the MOC?

2.4.1. Did the sponsor plan & implement care transition protocols to maintain member's continuity of care as defined in the MOC?

2.3: *Did the ICP include measurable outcomes in accordance with the MOC?*

Measurable and specific goals take the ambiguity out of what the member is wanting to accomplish
Measurable and specific goals quantifies what the patient is aiming for

Fact: Measurable goals are not found just in health care, schools use them for IEP plans, businesses to help achieve outcomes, substance abuse prevention programs etc.

Goals fall into common domains (e.g., health/wellness, services/care, lifestyle, independent living). However, how people set and speak about their goals varies. People tend to speak about what is important in their life—including their goals—in ways that are meaningful to them:

"Stay away from the 'bad' part of town (where I'm tempted to use drugs)."

"No, I don't want to use the walker; I don't want to become dependent on that thing."

"I want to live here forever; it was my mother's house, too."

Stated Goal	SMART Goal
"The main one is to keep trying to move, walk and do some of the things I like to do."	1. Member *(Genevieve)* will have a pain level of 4 or less, which will enable her to be more independent with her ADLs and IADLs. 2. Member *(Genevieve)* will lose 15 pounds over the next 6 months.

CMS wants to see measurable goals

DHS + CMS Requirements

What is a SMART Goal?

- Specific
- Measurable
- Attainable
- Relevant
- Time-Bound

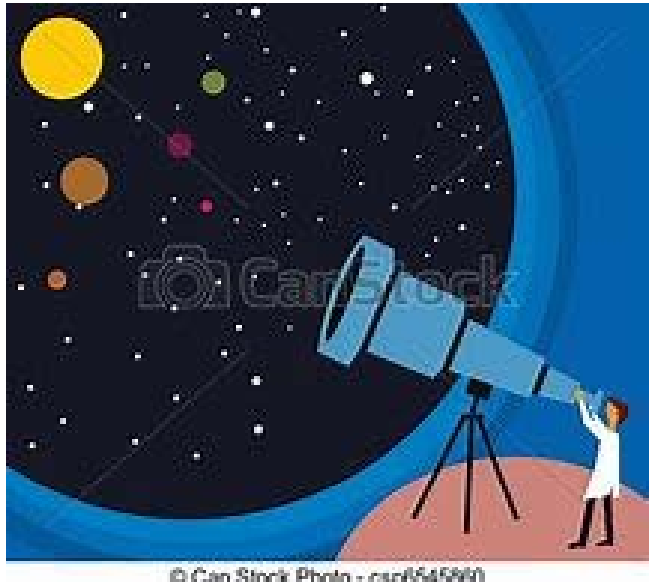
Specific

What is the member wanting to accomplish?
What are they aiming for?

Narrow the focus

Short and concise

Avoid generalizations- they can’t be measured

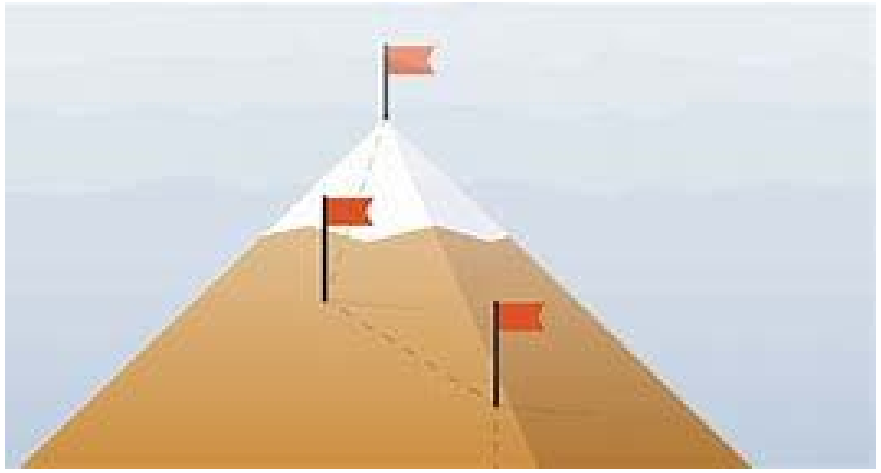


Measureable

Ask yourself, ‘How would I measure this?’

Non-Measurable	Measurable
Mary would like to have fewer falls	Mary will report zero falls or Mary would like to avoid having any falls over the next year
Mary would like to have an improvement in her overall pain caused from her arthritis over the next year.	Mary would like to rate her pain as less than 5
Mary would like to have as few seizures as possible	Mary will report less than 3 seizures
Mary and family would like weight to be stable over the next year	Mary will not gain more than 10 lbs

Attainable



Some goals need to be broken down into achievable steps/pieces.

Not Attainable	Attainable
Mary wants to lose 100 lbs	Mary will lose 10 lbs
	Mary will walk 5” 3x/day
	Mary will eat sweets no more than 3x/wk

Relevant

Relevant:

Make sure the goal reflects what's important to the individual. Use Motivational interviewing to help tie identified needs from the assessment to goals.

- Why is this goal important to the member?
- How will this goal benefit your member?
- Will the member stay committed to the goal?

Time-Bound

Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)

Time-bound is built into the care plan goal section; no need to restate in your goal

Care Planning for Assessed Needs

2.2.2. Did the sponsor develop a comprehensive ICP designed to address needs identified in the HRA, consistent with the MOC?

Clinical Needs

Identified Clinical Needs are missing from the care plan

My Health Concerns

F.4 Do you have any health problems? How do they affect you and how long have you had them? *(ASK:)* For instance, has a doctor ever told you that you have any of the following health problems?

Cardiovascular
- ☐ Chest Pain
- ☑ Ankle edema
- ☐ Shortness of breath
- ☑ Hypertension
- ☑ Other triple bypass with va

Respiratory
- ☐ Difficulty breathing (rest/exertion/pain)
- ☐ Asthma
- ☐ Cough (dry/productive)
- ☐ COPD (Emphysema)
- ☐ Other

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Bowel problems

Infectious Diseases
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ HIV positive (AIDS)
- ☐ STD
- ☐ Other

Genitourinary
- ☐ Difficult/frequent urination
- ☐ Frequent bladder infections
- ☐ Dribbling/incontinence
- ☐ Dialysis (type)
- ☑ Other CKD

Neurological
- ☐ CVA (Stroke)
- ☐ Parkinson's disease
- ☐ Seizures
- ☐ Dizziness
- ☑ Dementia (type)

Gynecological
- ☐ Breast changes
- ☐ Nipple discharge
- ☐ Vaginal discharge/bleeding
- ☐ Other

Musculoskeletal
- ☐ Osteoporosis
- ☐ Amputation
- ☑ Back pain
- ☐ Arthritis (type)
- ☑ Fractures
- ☐ Other

Cancer
- ☐ Type

Other
- ☐ Allergies

Clinically complex patient with multiple inpatient stays. No clinical conditions addressed on care plan. Case notes describe medical conditions.

Mary's blood pressure will remain below 150/90

Mary will not gain more than 3 lbs in one day.

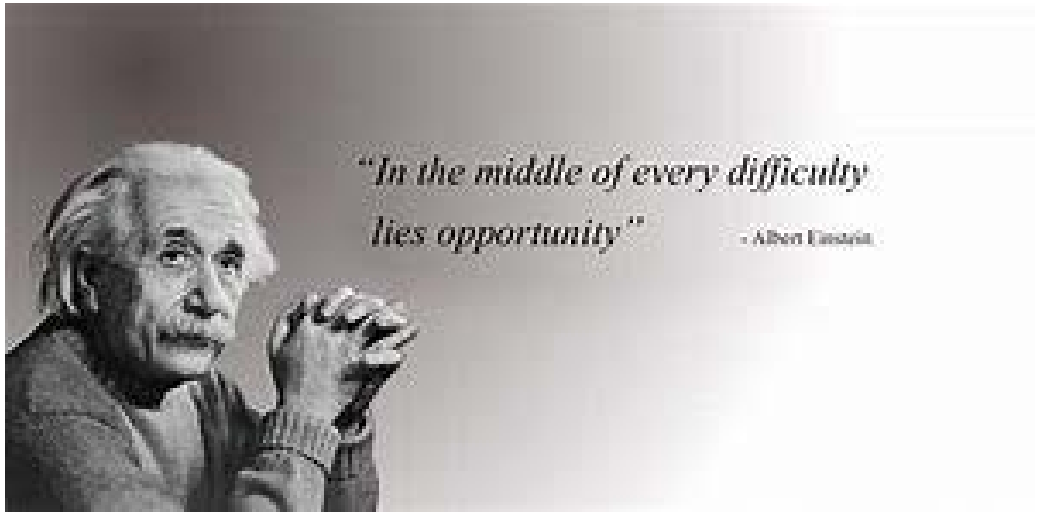
Mary will rate pain as less than 5 on a scale from 1-10

Mary will report 0 falls

Post Discharge Care Plan Updates

2.2.4. Was the ICP reviewed/revised based on the beneficiary's health condition and in accordance with the SNP's most recently approved MOC?

Easy Transition?



No, certainly not

Different way to think about care planning

Shorter goal target dates are needed. Not everything can wait 6 months to be reviewed- such as daily weights

- Especially when patients are discharged from the hospital with unstable medical conditions

Next Steps: Phase 1

Read Goals to Care article which will give you more context into care planning using a SMART goal approach

With each care plan you complete or update going forward, create 1 SMART goal

Phase 2

We will review care plans and provide additional training & tools

Care plans to evolve to include more SMART goals and statements

Continue to work closely with your leaders

Phase 3

Age and Odyssey conference 7/31-8/1 will have a SMART Goal care planning session

Training for our collaborative workgroup

Other health plans starting to train.