

PrimePartners

for Case Managers

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Minnesota Adult Abuse Reporting Center (MAARC)

Kristi Shamp, RN, BSN, CPHM, SNP Senior Care/UM Care Coordinator

Effective July 1, 2015, Minnesota launched the Minnesota Adult Abuse Reporting Center (MAARC), a new central system for reporting suspected maltreatment of vulnerable adults. MAARC is available 24 hours a day, 7 days a week, 365 days a year.

Voluntary and mandated reporters can call MAARC at **1-844-880-1574** (toll free). Mandated reporters can also file a report online at www.mn.gov/dhs/reportadultabuse. Reports will be promptly submitted to the appropriate investigative agencies.

If you have questions, please contact **Kristi Shamp**. 

HEDIS 2015 Results

Jordan Klimek, MS, PIP/HEDIS Coordinator

Another Healthcare Effectiveness Data and Information Set (HEDIS) season has come and gone. PrimeWest Health is required by our contracts with the Minnesota Department of Human Services (DHS) and the Centers for Medicare & Medicaid Services (CMS) to conduct these audits and report the results. Contracted providers are required to participate; however, more importantly, these audits can give us valuable information about how we can work to improve the lives of our members, your patients.

HEDIS 2015 involved an audit of 7,907 randomly selected records for services rendered in 2014. Some of the data reviewed are based solely on claims ("administrative"), while the remainder of the data are based on claims analysis and on-site record reviews ("hybrid"). The record review process is onerous for all concerned. We recognize this and appreciate your cooperation and the cooperation of your staff. One way to ease this burden is to make every effort to increase the use of Current Procedural Terminology (CPT) Category II codes. This will decrease the amount of information that must be obtained directly from your records. See "Top 5 Ways to Limit the Volume of HEDIS Records Reviewed in Your Clinic" at www.primewest.org/hedis-volume-limitations for additional information on Category II codes and other coding tips.

Opportunities for improvement

Adolescent Immunizations continued to improve overall, but **Childhood Immunizations** could use improvement. HEDIS looks to make sure all vaccinations are given *before* age 2, and it can be a challenge to get members in before their 2nd birthday. Encouraging members to set up appointments in advance can be helpful in this area.

Chlamydia Screening among females ages 16 – 24 improved this year, although rates are still well below national means. Chlamydia is ubiquitous in rural Minnesota as is the reluctance to openly confront sexual behavior in this population. The test, often a simple urine test, is frequently misconstrued as an implied or frank admission of misbehavior. Providers can help dispel this unfounded concern by positioning it as an important, standard, and judgment-free screening test.

Comprehensive Diabetes Care examines members ages 18 – 75 with diabetes. Because diabetes is a chronic, incurable condition that affects a broad segment of the population, it is important to focus on ways to keep the disease under control. This measure looks at the following key elements of keeping diabetes under control:

- Hemoglobin A1c (HbA1c) testing
- HbA1c control
- Eye exam (retinal)
- Medical attention for nephropathy
- Blood pressure control (<140/90 mm Hg)

While PrimeWest Health saw improvement over the last year in many of these areas, we hope to improve even more next year. Encouraging members to make healthy lifestyle choices such as eating right and exercising can help control blood pressure and blood sugar. Medical attention for nephropathy can be addressed through tests such as microalbumin, and annual eye exams should be encouraged.

Medication Reconciliation Post-Discharge (MRP) declined this year. This measure is an excellent example of where use of CPT Category II codes could help ease the chart review burden for clinics. This measure can require collection of office visit records and hospitalization records from the entire year. It is very stringent in terms of required documentation, and coding for this service can eliminate this challenge. “Top 5 Ways to Limit the Volume of HEDIS Records Reviewed in Your Clinic” specifically addresses MRP coding. You can access this document on our website at www.primewest.org/hedis-volume-limitations.

Osteoporosis Management of Women Who Had a Fracture saw a rate decline again this year. This measure looks at whether women had either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after a fracture. Primary prevention of osteoporosis is important as is prevention of falls, but don’t forget secondary prevention: manage osteoporosis to prevent the second or subsequent fracture in this select group of high-risk patients.

Well-Child Visits among children under age 15 months, ages 3 – 6, and ages 12 – 21 declined. These measures look for wellness visits that include a physical exam and address health history, physical development, mental development, and health education. HEDIS looks for six wellness visits in the 0 – 15 month age group and an annual visit for the other age groups. Providers can help improve this area by coding well-child exams appropriately and encouraging preventive care.

If you would like additional information about HEDIS and the processes involved, please see our Quality Performance web page at www.primewest.org/qualityperformance or contact **Jordan Klimek**. 

Prevention and Fast Track Intervention Strategies (FTIS) Protocol

Jennifer Bundy, RN, MSN, PHN, CMCN, CCP, Complex Care and Disease Management Manager

In line with best practice guidelines, PrimeWest Health is required by our Special Needs BasicCare (SNBC) contract with the Minnesota Department of Human Services (DHS) to have targeted interventions for populations with known high-risk factors for urinary tract infections (UTIs) and skin breakdown. PrimeWest Health has developed a Prevention and Fast Track Intervention Strategies (FTIS) protocol. The goals of the protocol are to improve quality of life; increase early identification; provide education; assist with self-management skills; ensure coordination of services for the prevention, intervention, and remission of UTIs and skin breakdown; encourage support and participation from members of the Interdisciplinary Care Team (ICT), family, friends, and community; and support community living.

FTIS protocols are evidence-based guidelines that help providers devise individualized care plans and help caretakers focus on the overarching task of providing reliable health care for people with special needs.

The FTIS protocol is used to help recognize key areas for prevention, identify when and where prevention has failed, mitigate the consequences in these instances, and redesign or reassess the applicable care processes. The FTIS protocol alerts PrimeWest Health to possible improvements in the care processes and the potential for positive outcomes from focused and personalized case management.

The FTIS protocol was previously provided to county case managers along with the *FTIS Notification and Update Form*. If you would like a copy of the protocol, please contact **Jennifer Bundy**. You can access the *FTIS Notification and Update Form* on the PrimeWest Health website at www.primewest.org/county-case-manager-forms.

You can also find a *Urinary Tract Infection (UTI) Care Strategy* on the website at www.primewest.org/countycasemanagerresources. County case managers are encouraged to help members complete this document to help them manage their UTIs. You can find *Skin Integrity Guidelines* at the end of this issue. County case managers can use this document to help develop member care plans that address concerns related to skin integrity. 

A Brief Overview of Person-Centered Planning

Ann Tesch, RN, BSN, PHN, CCP, Complex Care Coordinator

Person-centered planning is not a new concept. It has been around for almost 20 years. It is currently receiving more emphasis due to legislative changes and the importance placed on the subject by the Centers for Medicare & Medicaid Services (CMS).

According to the Learning Community for Person Centered Practices, person-centered planning is focused on a different way of thinking—respecting each person for what is important to him/her and how he/she wants to live, while keeping in mind what is important for the person to stay healthy and safe. A good person-centered plan reflects a balance between what is important *to* the person and what is important *for* the person. The plan describes the person's strengths, preferences, and capacities, and what he/she needs to stay healthy and safe. The plan clearly identifies those people involved in the Interdisciplinary Care Team (ICT) and their roles and contact information.

CMS provides a description of the person-centered care plan that covers the planning process, care plan, and review process.

The planning process should include the following:

- People chosen by the member and/or member's family
- Information and support so that the member and/or family can direct the process and make informed choices about services and support
- Timely meetings that occur at a time and place that is convenient for the member and/or family (in a clinical setting, this will most often occur in the health care provider's office)
- Consideration of the member and/or family's cultural needs with information presented in plain language that is accessible to everyone, including people with limited English proficiency
- Strategies for solving conflict and disagreements
- Choice of services and support
- A method to request an update to the person-centered plan

The care plan must be understandable to the member receiving the services and support, be finalized and agreed to, provide informed consent, and be signed by all individuals and providers responsible for its implementation. It should be distributed to the member and other people involved in the plan and should avoid unnecessary or inappropriate services and support.

In addition, the services must include the following elements:

- The member's strengths and preferences
- Clinical and support needs that are identified through the functional assessment
- Individually identified goals and outcomes
- The services and support that will help the member achieve the identified goals along with the individuals responsible for providing those services and support
- Risk factors and measures to minimize possible risks
- The person and/or entity responsible for monitoring the plan
- Any self-directed services
- Modifications to home and community based settings (any place the member may work, receive services, live, etc.)

All person-centered planning should be reviewed at least every 12 months. It should be reviewed sooner if there is a significant change in a member's circumstances or needs. Person-centered planning doesn't occur one time only; it is a continual process and is constantly changing based upon the changing needs of the person.

For additional information on person-centered planning or for assistance with person-centered planning tools, please contact **Ann Tesch**.

Sources: CMS. "Final Rule Medicaid HCBS." Accessed August 25, 2015, www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/final-rule-slides-01292014.pdf.

The Learning Community for Person Centered Practices. Accessed August 25, 2015, www.learningcommunity.us/home.html. 

Supporting Members on Chemotherapy

Elizabeth Warfield, RN, BSN, Senior Care Coordinator

The importance of supporting members who are on chemotherapy cannot be overstated. The turmoil surrounding a diagnosis of cancer and the decision to start chemotherapy can make it difficult for members to understand and retain all of the important information and instructions their oncology team provides. Keeping this information straight, however, is imperative. Failure to do so can lead to unwanted side effects, treatment delays, and potentially avoidable hospitalizations. Because of this, members need extensive support during chemotherapy, especially during their first two cycles.

County case managers can provide support to members undergoing chemotherapy in the following ways:

- Become familiar with the chemotherapy medications in the member's regimen and the common side effects
- Make frequent contact with the member during his/her first two cycles of chemotherapy
- Determine if the member understands how to manage expected side effects. If not, offer to help the member get this information from his/her oncology team.
- Encourage frequent communication with the member's oncology team about any change in symptoms and questions about medications
- Make sure the member knows the importance of reporting a fever to his/her oncology team. Although each oncologist's directions may differ, a fever greater than 100°F should be reported. Emphasize that infections can become serious quickly, especially if the member becomes neutropenic from chemotherapy.
- Encourage the member to wash his/her hands frequently and avoid crowds and sick people, especially during the member's nadir (the period of time when the white blood cell count is lowest in the chemotherapy cycle, typically 7 – 12 days after chemotherapy depending on the regimen)
- Encourage members to allow reliable family members or home care nurses to help with medication set up to help prevent inadequate treatment (underdosing) or toxicity (overdosing). Oral chemotherapy regimens vary from one tablet daily to multiple tablets in more than one strength, 1 – 2 times daily for a certain number of days followed by a specific amount of time off. This can be very confusing for members to keep straight.

Caught early, many of the side effects from chemotherapy—even infections—can be managed without hospitalization. Avoiding these hospitalizations through member support and appropriate symptom management/reporting will help ensure adequate treatment, greatly enhance the quality of life of our members on chemotherapy, and help decrease the high cost of treating cancer.

Sources: 3 Steps Toward Preventing Infections During Cancer (3 Steps). “Understanding Your Risk for Infection during Chemotherapy.” Accessed August 25, 2015, www.preventcancerinfections.org/health-tip-sheet/understanding-your-risk-infection-during-chemotherapy.

American Health & Drug Benefits (AHDB). “Poor Adherence to Oral Cancer Drugs a Growing Concern.” Accessed August 25, 2015, www.ahdbonline.com/issues/2013/august-2013-vol-6-no-6-special-issue/1502-article-1502.

Brooks, Gabriel A., Thomas A. Abrams, Jeffrey A. Meyerhardt, Peter C. Enzinger, Karen Sommer, Carole K. Dalby, Hajime Uno, Joseph O. Jacobson, Charles S. Fuchs, and Deborah Schrag. “Identification of Potentially Avoidable Hospitalizations in Patients with GI Cancer.” *Journal of Clinical Oncology* 32, no. 6 (February 2014), accessed August 25, 2015, www.jco.ascopubs.org/content/32/6/496.full.pdf+html. 

Individual Assistance with Food Preparation and Congregate Meal Preparation in Customized Living (CL) Settings

Kristi Shamp, RN, BSN, CPHM, SNP Senior Care/UM Care Coordinator

As a reminder, individual assistance with food preparation and congregate meal preparation are both component services in Customized Living (CL) settings that can be authorized when there is an assessed need for assistance. Individual assistance takes place in the member’s living unit while congregate meal preparation takes place in a collective setting, such as a dining room.

Individual assistance with food preparation

This service component includes help with the preparation of food that has been purchased by the individual and that occurs within the individual’s living unit. Typical tasks include help with cooking, labeling and organizing food, making food accessible, throwing out spoiled food, and developing a menu. County case managers should ensure that duplication of services is not occurring, especially with congregate meal preparation and housekeeping.

Congregate meal preparation

This service encompasses all food preparation and services performed in a collective dining setting that are required to meet the member’s needs. This could include, but is not limited to, preparing food for special dietary needs, cutting up food, buttering bread, and tray delivery.

Waiver funds should be used to cover food preparation for members who are also receiving Group Residential Housing (GRH) funds. GRH funds are not an appropriate payment source for this service and GRH should always be considered the payer of last resort.

According to MN Stat. sec. 256B.0915, subd. 3 (e), a provider may not bill or otherwise charge a participant for additional units of any available component service beyond those approved in the service plan by the lead agency.

If you have questions, please contact **Kristi Shamp**. 

Model of Care: Part 1 of 4

The Model of Care is a set of guidelines PrimeWest Health developed that help us ensure our members get the best care with the best outcomes. It provides a step-by-step process to develop personalized care plans for our members enrolled in PrimeWest Senior Health Complete (HMO SNP) and Prime Health Complete (HMO SNP). You can review the Model of Care for each program on our website at www.primewest.org/modelofcare.

PrimeWest Health's 2015 Model of Care was approved upon PrimeWest Health's **first** submission to the Centers for Medicare & Medicaid Services (CMS), receiving a three-year approval and a score of 60/60.

In this issue, we are beginning a series of articles that will highlight the key details from each chapter of the Model of Care.

Chapter 1

Chapter 1 of the Model of Care provides a description of the Special Needs Plan (SNP) population. It includes qualifications for enrollment in PrimeWest Senior Health Complete and Prime Health Complete, characteristics of members in each program, and information on the most vulnerable members of this population. These are summarized below.

Enrollment qualifications

The following are criteria that a person must meet to be enrolled in each program.

PrimeWest Senior Health Complete

- Age 65 years or over
- Eligible for Medical Assistance (Medicaid) and Medicare Parts A and B or Medical Assistance (Medicaid) only
- Resident of a PrimeWest Health county
- Eligible to enroll in Minnesota Senior Care Plus (MSC+)

Prime Health Complete

- Ages 18 – 64
- Eligible for Medical Assistance (Medicaid)
- Resident of a PrimeWest Health county
- Certified disabled or developmentally disabled

Member characteristics

The following are general characteristics that describe most, but not all, members of each program.

PrimeWest Senior Health Complete

- Over age 82
- Single (widowed)
- White
- Female
- English-speaking
- Below the poverty level (all PrimeWest Senior Health Complete members are Medical Assistance [Medicaid]-eligible)
- Probability of having two or more chronic conditions (heart disease primary) with possibility of a mental health diagnosis
- Low probability of having a chemical health concern
- High probability of having nine prescriptions per month (includes over-the-counter drugs)
- Probability of living in a community setting

Prime Health Complete

- Average age is 51
- Single
- White
- English-speaking
- Almost equal chance of being male or female
- Below the poverty level (all Prime Health Complete members are Medical Assistance [Medicaid]-eligible)
- Probability of having one or more chronic conditions (depression primary) with high probability of heart disease
- Low probability of having a chemical health concern
- High probability of having eight prescriptions per month (includes over-the-counter drugs)
- High probability of living in a community setting

- High probability of receiving additional Home and Community Based Services (HCBS) such as homemaking and Meals on Wheels to allow the member to live in a community setting and avoid institutionalization
- Potential for physical or emotional problems affecting social activities
- Considers self to be of Christian faith
- Probability of being a smoker or past smoker
- High probability of no Internet use
- High probability of 8th – 12th grade education
- Probability of having caregiver support is lower than the national average
- High probability of both hearing and vision deficits
- High probability of difficulty walking
- High probability of transportation issues
- Very low probability of identified gaps in service provision between Medicare and Medical Assistance (Medicaid) services
- Receives excellent and timely access to necessary services, including primary and specialty care and Part D services
- Low probability of overutilization of services
- Ranks chosen county case manager and/or PrimeWest Health care coordinator as helpful with concerns (over 98.5 percent satisfaction)
- High probability of rating quality of life as excellent to very good

- High probability of receiving additional non-health plan-covered waiver services from the county of residence
- Potential for physical or emotional problems affecting social activities
- Considers self to be of Christian faith
- Probability of being a smoker or past smoker
- High probability of being a high school graduate
- Low probability of having a hearing impairment; average probability of needing corrective lenses for vision impairment
- High probability of difficulty walking
- Probability of having caregiver support is lower than the national average
- Very low probability of identified gaps in service provision between Medicare and Medical Assistance (Medicaid) services
- Receives timely access to necessary services (above the Minnesota average), including primary and specialty care services
- Ranks chosen county case manager and/or PrimeWest Health care coordinator as helpful with concerns (over 98 percent satisfaction)
- High probability of rating quality of life as excellent to very good
- Probability of perceiving their overall mental or emotional health to be unchanged from previous year
- Moderate probability of needing transportation services

Most vulnerable members

Members of PrimeWest Senior Health Complete and Prime Health Complete who are considered the most vulnerable are identified by the following:

- Frequency of hospitalization – three hospitalizations in three months (three members identified in 2013)
- Readmissions to the hospital within 30 days of discharge (three members identified in 2013)
- Lengths of stay greater than four days (16 members identified in 2013)
- Six emergency room visits in previous three months (two members identified in 2013)
- Ten or more office visits in previous three months (18 members identified in 2013)
- \$100,000 or more in medical expenses including pharmacy and hospitalizations in the last year (eight members identified in 2013)
- Three or more chronic conditions (61 members identified in 2013)

County case managers are notified when PrimeWest Health identifies a member who falls into the “most vulnerable” population.

We hope knowing the characteristics of, and challenges faced by, our SNP members will be useful to you. For more information, please contact **Catie Lee**. 

Important Dates

✓ County supervisor meeting

Meetings are held on the third Thursday of the month, 10 a.m. – 3 p.m., at PrimeWest Health in Alexandria, unless otherwise noted.

September 17

October 15

November 19

December 17

✓ County case management educational training

Trainings are held on the fourth Wednesday of the month via webinar from 10 a.m. – noon, unless otherwise noted.

September 23

October 28

November 25

December 23

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You can find a PDF copy of *PrimePartners* by going to our website. Go to www.primewest.org/primepartners.

Skin Integrity Guidelines

Risk Factors/Goals

Potential Interventions

GOAL: Monitor the condition of skin and risk factors to ensure skin integrity

Potential Interventions:

- ☐ Inspect skin daily with cares (done by nursing assistants)
- ☐ Inspect skin weekly by licensed nurse
- ☐ Risk assessment per protocols
- ☐ Documentation of skin integrity concerns (i.e., pressure ulcer) at least weekly
- ☐ Weekly foot care and Podiatrist as appropriate

GOAL: Promote circulation to tissues by reducing or eliminating pressure

Possible risk factors that decrease circulation or cause unrelieved pressure to tissues:

- Immobility (diagnosis that leads to immobility, such as CVA, MS, end stage Alzheimer's, etc.)
- Decreased sensory perception (inability to feel pressure)
- Cognitively impaired (inability to communicate pressure or inability to move themselves)
- Cardiovascular disease
- PVD
- Bed bound or chair-fast
- Contractures (leading to pressure points)
- HOB elevated the majority of the day
- Assist with ADLs
- History of pressure ulcers
- Restraints
- Pain
- Medications that cause lethargy

Potential Interventions:

- ☐ Provide appropriate redistribution surface in the bed
- ☐ Provide appropriate pressure redistribution surface in the wheelchair
- ☐ Provide appropriate turning and repositioning schedules for when in the bed and wheelchair
- ☐ Provide appropriate heel lift
- ☐ Provide appropriate positioning devices such as pillows and foam wedges
- ☐ Referral to Therapy as appropriate
- ☐ Check and release restraints at appropriate intervals
- ☐ No more than 30 degree side lying or head elevation unless contraindicated
- ☐ Monitor and manage pain
- ☐ Monitor and manage diabetes as ordered
- ☐ Monitor steroid use and work with Physician/NP to maintain lowest possible dose

Skin Integrity Guidelines

Risk Factors/Goals	Potential Interventions
■ Medical devices that may be a source of pressure ■ Fractures leading to impaired mobility ■ Smoker or history of smoking (decrease circulation to areas) ■ Diabetes (leads to circulatory concerns, neuropathy and decreased ability to heal) ■ Steroid use (decrease ability to heal)	
GOAL: Prevent skin breakdown secondary to moisture concerns	
Possible risk factors that could contribute to excess moisture to the skin: ■ Incontinent of bladder ■ Incontinent of bowel ■ Excessive perspiration	Potential Interventions: ☐ Barrier ointment to protect the skin from incontinence ☐ Peri care after each incontinence episode ☐ Individualized toileting plan ☐ Wash clothes or pillow cases between skin folds to pick up moisture and prevent skin to skin contact; change with AM and PM cares
GOAL: Prevent shearing or friction forces	
Possible risk factors that could lead to shear and friction forces: ■ Sliding or slouching in the bed or wheelchair ■ Fragile skin integrity ■ Needing assistance with mobility ■ Tremors ■ Combative with cares	Potential Interventions: ☐ Slightly raise the foot of bed before raising the head of the bed ☐ PT/OT referral for wheelchair positioning ☐ Use lifting devices when moving residents ☐ Lift do not slide residents ☐ Provide arm or leg protectors ☐ Skin sealants or dressing to protect fragile skin ☐ Keep dry skin well lubricated ☐ Bath with mild soap, gently pat dry

Skin Integrity Guidelines	
Risk Factors/Goals	Potential Interventions
GOAL: Promote proper nutrition for wound healing and prevention of skin breakdown	
Possible risk factors that could lead to nutritional deficits: ■ Low Albumin and/or pre-albumin ■ Inadequate intake/poor appetite ■ Inability to feed themselves ■ Difficulty swallowing/aspiration risk ■ Very low or very high body weight ■ Dehydration or history of dehydration ■ Significant weight loss ■ Tube feeding ■ Diabetes	Potential Interventions: ☐ Dietary referral ☐ Provide supplementation per dietary recommendations ☐ Provide vitamin and mineral support per dietary recommendations ☐ Monitor in-take ☐ Monitor weights as indicated ☐ Monitor labs as appropriate ☐ Monitor/manage diabetes as ordered ☐ Individualize diet to resident preference as much as possible
GOAL: Ensure resident and family/designee have proper knowledge of prevention and treatment of skin breakdown	
	Potential Interventions: ☐ Provide education on causes of pressure ulcers and interventions to prevent or promote healing to resident and family/designee ☐ Provide risk/benefit of any interventions resident/family/designee is choosing not to follow ☐ Provide psychosocial support as appropriate

Source: The Indiana Pressure Ulcer Initiative, an initiative of the Indiana State Department of Health and the University of Indianapolis Center for Aging & Community. 2009. Version: Oct. 2, 2009. Available online: www.in.gov/isdh/files/Skin_Integrity_Guidelines_T2.pdf.