GOAL MONITORING: PROGRESS AND OUTCOMES

Collaborative Care Plan development is based on available information including issues or needs identified in the assessments, medical records and/or previous utilization, and member and/or family input.

Care Coordinator is responsible to coordinate primary, acute, long-term care, mental health, and social service needs of each member and provides communication and collaboration across all providers.

Incorporate a holistic and preventative focus, and should address Advance Directive planning.
CARE PLAN RESOURCES

MSHO and MSC+ Guidelines for Community Members
- Section titled: Comprehensive Care Plan

6.02.01 Collaborative Care Plan
6.02.02 Instructions for the Collaborative Care Plan

Found on the care coordination web portal:
https://carecoordination.bluecrossmn.com/manuals-guides/secureblue-msho/

CARE PLANNING ELEMENTS

Member
- Medical
- Contract Obligations
- Risk and Safety Needs
- Social/Family
- Service Needs
- Person’s Choices
### DOCUMENTING PROGRESS OF THE GOALS

- The Care Coordinator should have a discussion with the member about each goal and the member’s progress toward meeting the goal.
- Discussion should include determining if the goal was met or not met and an evaluation of whether the goal will be discontinued, modified, or carried forward.
- Document progress of goals on the care plan at the 6 month visit and throughout the year as needed.
- Include the month/year of the review and a brief progress note in the **monitoring progress/goal revision date** column.

<table>
<thead>
<tr>
<th>Rank by Priority</th>
<th>My Goals</th>
<th>Support Needed</th>
<th>Target Date</th>
<th>Monitoring Progress/Goal Revision Date</th>
<th>Date Goal Achieved/ Not Achieved (Month/Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
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<td></td>
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<td></td>
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<tr>
<td>Medium</td>
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Discussion should include determining if the goal was met or not met and an evaluation of whether the goal will be discontinued, modified, or carried forward.
GOAL OUTCOME DOCUMENTATION

Outcomes are documented in this column

Document the outcome of each goal as follows:

1. For each goal, document the month and year
2. Note the following:
   - Goal achieved or not achieved
   - Document whether goal will be continued, modified or discontinued
3. You may also document a progress note in this column

<table>
<thead>
<tr>
<th>Date Goal Achieved/ Not Achieved (Month/Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/2018 Goal met. Discontinue goal.</td>
</tr>
</tbody>
</table>

SAMPLE OF GOAL MONITORING

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<td>Jane wants to be free of falls over the next year.</td>
<td>CC will arrange a Physical Therapy safety assessment. Customized Living staff will assist with transfers in and out of chairs and bed for safety.</td>
<td>1/1/19</td>
</tr>
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Here is an example of documenting an outcome.
SAMPLE OF OUTCOME DOCUMENTATION

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<td>Low</td>
<td>Jane wants to be free of falls over the next year.</td>
<td>CC will arrange a Physical Therapy safety assessment. Customized living staff will assist with transfers in and out of chairs and bed for safety.</td>
<td>1/1/19</td>
<td>3/2018 PT evaluation completed and recommendations given to customized living staff. 6/2018 Customized living staff continue to assist with transfers in and out of bed and throughout the day.</td>
<td>1/2019 Goal met. Continued goal on next year’s care plan.</td>
</tr>
</tbody>
</table>

GOAL OUTCOME TIPS

- Every goal outcome must be documented at reassessment on the current care plan before completing the new care plan.
- If you document that the goal is carried forward to next year’s care plan, be sure that it is written on the next year’s care plan.
COLLABORATIVE CARE PLAN TIPS

- Do not use the word “on-going” as the target date
- Use Care Plan as a living document and write updates directly on the document
  - Use in your work with member throughout the year
- At member visits bring a copy of the care plan with you to review the goals
- Update care plan goals at minimum twice per year & with any health status changes
- Document the final outcome of each goal
  - Will it be: Goal Met; Goal Continued; or Goal Modified

DHS AUDIT PROTOCOL

Managed Care (MSHO and MSC+) Elderly Waiver Care Planning Audit
(as required under 7.1.4.D., 7.8.3, and 9.3.7 of the 2016 MSHO/MSC+ contract)

Audit Protocol

Desired Outcome: The enrollee’s goals or skills to be achieved are included in plan, are related to the enrollee’s preferences and how the enrollee wants to live their life, and there is a plan to achieve their goals.

8. COMPREHENSIVE CARE PLAN – Goals

Be familiar with DHS audit protocol
DHS AUDIT PROTOCOL

Method for measuring outcome achievement (met as determined by all of the following):

a. Goals and skills selected by the enrollee to be achieved are clearly described; 
   and 

b. Action steps, including services or supports needed, are identified and describe what needs to be done 
   to assist the enrollee to achieve the goals or skills; 
   and 

c. Plan for monitoring progress towards goals is included; 
   and 

d. Target dates for completion are included (at least month and year); 
   and 

e. Outcome/achievement dates are included; 
   and 

f. People/providers responsible for assisting the enrollee in completing each step are identified.

PREVENTING AUDIT ERRORS

- Auditors give you the member sampling list 30 days prior to the audit. Use 
  that time to get your files ready to go.

- Prior to audit review the CCP. If you completed the goal discussion with the 
  member, but forgot to document it on the care plan, it is OK to do so now. 
  Caution: You cannot do this if the goal review did not occur.

- If required elements are not completed or are delayed, document, document, 
  document.

- If goal progress and outcome documentation is not on the care plan, flag the 
  auditor as to where it is located. If auditor can’t find the documentation you 
  will not get credit.

- Electronic records: if progress and outcomes documentation is separate from 
  the complete CCP, be sure to have it labeled for easy identification.
RESOURCES

Blue Plus’ Care Coordination Web Portal:
https://carecoordination.bluecrossmn.com/

On the portal you can find:
- Care Coordination Guidelines Community Members—
  Section titled: Comprehensive Care Planning
- 6.02.01 Collaborative Care Plan
- 6.02.02 Instructions for the Collaborative Care Plan

Partner Relations Consultant assigned to your agency

THANK YOU.

Blue Plus Partner Relations Team