DOCUMENTATION FOR CARE COORDINATION

Human Services Department,
State of New Mexico

June 13, 2017
INTRODUCTIONS:
CARE COORDINATION UNIT/QB/MAD

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AGENDA

- Introduction to HSD
- Contract and Policy
- Documentation Best Practices
- Care Coordination Touchpoints
- Tips for CNA and CCP
- Audit Findings
- Transitions of Care
- Back-up and Disaster Plans
- Resources
INTRODUCTION TO HSD

- How Medicaid works
- Human Services Department, New Mexico
- Care Coordination Unit/QB/MAD/HSD
- What we can offer you today
CONTRACT AND POLICY

- Medical Assistance Division Contracts:  
  [http://www.hsd.state.nm.us/LookingForInformation/medical-assistance-division.aspx](http://www.hsd.state.nm.us/LookingForInformation/medical-assistance-division.aspx)

- Managed Care Policy Manual:  

- Or Google “HSD NM” > Search “contract” or “policy manual”
BEST PRACTICES: HOW TO RECORD

- Up-to-date
- Accurate
- Consistent
- Concise
- Readily identifiable
- Meaningful
- Bullet points

“If it isn’t documented, it hasn’t been done”
BEST PRACTICES: WHAT TO RECORD

- Member History
- Member Needs
- Member Goals
- Services Rendered
- Outcomes, Progress, Satisfaction
- Overlap with other Case Management
Who’s your audience?
Start with the facts
First things first
Who’s story is this?
When in doubt, document
Careful with documentation by exception
Observe strengths and accomplishments
CASE MANAGEMENT OVERLAP

Where else is this member receiving case management?

- PACE
- Nursing Facility
- Corrections
- Other Institutional Care
- Medically Fragile Waiver
- Developmental Disabilities Waiver
- Mi Via

Approach:

- Reduce duplication of services
- Streamline goals
- Inter-disciplinary care
CC TOUCHPOINTS: COLLABORATION WITH WAIVER CASE MANAGERS

- **DDW**
  - DOH DDW Case Manager
  - DDSD Regional Case Management Coordinator

- **MFW**
  - UNM MFCMP Case Manager

- **Mi Via**
  - DOH Mi Via Consultant
**CC Touchpoints: Collaboration with Waiver Case Managers**

**Policy Manual:** Consult pp. 39-43 for specific guidelines.

**CNA/CCP:**
- Obtain LOC abstract (MAD 378) and CIA from TPA (DDW & Mi Via)
- Obtain MFW LOC packet and ISP from UNM/MFCMP (MFW)
- For MFW and Mi Via, conduct CNA with case manager.

**Touchpoints:** For MFW, CC is not required to complete other touchpoints. Instead, obtain monthly notes and update CNA.

**NFLOC:** Members in these programs don’t need a NFLOC assessment.

**Consult experts:** Consult member’s case manager, guardian, any legal representative, or an expert within your MCO.
THE BASICS
Care Coordination Touchpoints: Continuous Monitoring and Documentation

Know the timelines.....
CC Touchpoints: CCL2 and CCL3

CCL2
- Annual CNA
- Bi-annual Home Visits
- Quarterly Phone Calls

CCL3
- Bi-annual CNA
- Quarterly Home Visits
- Monthly Phone Calls
CC TOUCHPOINTS: THE HRA

- Conduct HRA following enrollment
- Conduct HRA upon change of health condition if not yet assigned to CCL2 or CCL3 (4.4.2.1)
- Document all attempts made to conduct the HRA
- Within 7 days, inform members of the need for a CNA
Practice your interview skills often

Role play with a team member or your supervisor

- SCHEDULE CNA within 14 days of HRA completion
- COMPLETE CNA within 30 days of HRA completion
- Ensure Minimum Data Set (MDS) is completed by nursing facility for nursing facility residents
- CNAs must be conducted in person, in the member’s home. Or, a CNA Exception (MAD 601) must be approved by HSD.
CC Touchpoints: The CBSQ

- Community Benefits are available to members meeting Nursing Facility Level of Care - NF LOC
- OPTIONS: Self-Direction or Agency Based

- CBSQ/CBMA completed simultaneously with CNA
- Conduct CBSQ annually or more for CCL3, NFLOC
- Document all refusals for NFLOC
- Document all refusals of CB services
CC Touchpoints: The CCP

- Eligibility status
- Identify service gaps
- Coordinate with providers
GOALS

Improving self-care and finding independence are *fine* goals.

But, *specific* goals that include amount, duration, and frequency are better.

**Tip:** Document instances when the Member is assigned a new Care Coordinator
CNA AND CCP BEST PRACTICES

- Complete CCP within timeframes
- Keep CCP and CNA in member record
- Document all persons involved
Break

DON'T FORGET TO STRETCH!!
TOP FIVE AUDIT FINDINGS

1. Source of BH diagnoses
2. Action list related to goals
3. Document updates as updates
4. Disaster/back-up plans
5. Transitions of care
Audit Process

Does the file document participation in development of the care plan by others including family, representative, current caregivers/providers? (4.4.9.3)

Does the member file contain documentation showing utilization of local resources such as Peer Support Specialists, Tribal services, and/or Community Support Workers for care coordination? (4.4.12.2)

Does the member file contain evidence showing the MCO conducted the CNA within the contractual timeframes? (4.4.3.3.3)
TRANSITIONS OF CARE

- Institutional facility to community
- One MCO to another
- Out of EPSDT
- Higher to lower level of care

MCO contract reference 4.4.15.2
**Transition of Care Plan**

- **Label**
- **Stand alone or in CCP**
- **Assessment within 75 days**

**Contents**
- Physical and BH needs
- Selection of providers
- Housing
- Financial
- Safety
- Interpersonal skills

MCO contract references
4.4.15, 4.4.16
**TRANSITION OF CARE PLAN**

**MCO Contract (effective 1/1/14):**
The transition plan shall address the Member’s transition needs including but not limited to:

- 4.4.15.2.1 Physical and Behavioral Health needs
- 4.4.15.2.2 Selection of providers in the community;
- 4.4.15.2.3 Housing needs;
- 4.4.15.2.4 Financial needs;
- 4.4.15.2.5 Interpersonal skills; and
- 4.4.15.2.6 Safety.

4.4.15.3 The CONTRACTOR shall conduct an additional assessment within seventy-five (75) Calendar days of transition to determine if the transition was successful and identify any remaining needs.

**MCO Policy Manual (revised 3/1/17, page 46):**
... transition plan which must be labeled “Transition of Care Plan” and may be a stand-alone document or included in the Comprehensive Care Plan (CCP). If included as a part of the CCP, the “Transition of Care Plan” must be clearly labeled for MCO tracking and HSD auditing prior to the member’s discharge. The transition plan shall remain in place for a minimum of sixty (60) calendar days from the date of the decision to pursue transition or until the transition has occurred.
RESOURCES

Types
- Rent assistance
- Legal aid
- DME
- Senior companion
- Food bank, Meals on Wheels
- Employment supports
- Tribal Liaison, CHW, PSS
- ISD

Outcome
- Member acceptance
- Resource utilization

MCO contract references
4.4.5.5.5, 4.4.9.6.11
BACK UP/DISASTER PLANS

Back up
Caregiver
Medication
Transport

Disaster
Flood
Wildfire
Chemical

Both
Specific
Update
Ongoing
Articulate

MCO contract references
4.4.9.6.4, 4.4.9.6.18
CONTINUITY OF DOCUMENTATION

Next steps: Do my documents align?

in Alignment

out of Alignment
Can you guess the acronym?
Can you guess the acronym?

NFLOC - Nursing Facility Level of Care

CBSQ - Community Benefits Services Questionnaire

CBMA - Community Benefits Services Agreement

ISD - Income Support Division

MFW - Medically Fragile Waiver

ISP - Individualized Service Plan

UNM MFCMP - University of New Mexico Medically Fragile Case Management Program
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