Spotlight On The Wisconsin STAR Method: Care Wisconsin's Approach To Person-Centered Assessment And Care Management For Dually Eligible Beneficiaries

This spotlight describes a person-centered care management approach called the Wisconsin STAR Method, a simple process that supports care team members in visually mapping out the numerous interacting factors that often arise when caring for individuals with complex medical, social, and behavioral health needs, including those who are dually eligible for both Medicare and Medicaid.[1] This thorough assessment approach helps Care Wisconsin staff to pinpoint root causes of health care issues that have a large impact on health and financial outcomes, yet are often amenable to simple practical solutions (e.g., basic social or environmental modifications).

Care Wisconsin was founded in 1976 as the Madison area's first adult day care center, originally known as ElderCare. They expanded programs through the 1990s and 2000s to meet demands for long-term services and supports (LTSS) and in 2005 received their license to operate as a managed care plan. They now serve older adults and individuals with disabilities across 51 counties in Wisconsin. Care Wisconsin offers a variety of programs including a Medicare Advantage program (Dual Eligible Special Need Plan) for dually eligible beneficiaries.

Wisconsin Star Method – Background

The Wisconsin STAR method was first developed by Dr. Timothy Howell, a University of Wisconsin geriatric psychiatrist, in an effort to better understand and respond to the needs of older adults with complex, chronic, and co-occurring conditions. In 2016, Care Wisconsin decided to take a closer look at the root causes of high medical service utilization among their population dually eligible for Medicare and Medicaid; they chose the systematic and holistic approach of the Wisconsin STAR Method. One of the key benefits of the Wisconsin STAR Method is the structure it provides interdisciplinary care teams to help them systematically consider the full spectrum of factors that may affect an individual's health. It uses a visual approach and encourages providers to work collaboratively to identify a single primary challenge and then map out factors affecting health that are most relevant, as opposed to each provider relying on his or her individual, subjective viewpoints.

"…the Wisconsin Star Method represents a user-friendly way for clinicians and planners of care models to obtain a grasp on complex situations, not only more rapidly but also more effectively…"
-Dr. Timothy Howell, University of Wisconsin

To use the Wisconsin STAR method, the care team selects a single "primary identifiable challenge" for a given member on which to focus (e.g.

[1] Howell, T. (2015). The Wisconsin star method: understanding and addressing complexity in geriatrics. In *Geriatrics Models of Care* (pp. 87-94). Springer, Cham.

frequent ER visits or hospitalizations) and then conducts a comprehensive, holistic identification of potential contributing factors affecting the member's health and well-being in five domains. These are briefly described below, and a detailed list of potential factors for each domain is available from the Wisconsin Geriatric Psychiatry Initiative (WGPI).[2]

Image adapted from Wisconsin Geriatric Psychiatry Initiative (WGPI)

- **Medication factors** – includes prescribed, over-the-counter, and borrowed medications as well as adverse drug reactions
- **Medical factors** – diagnoses, symptoms and functional status (activities of daily living, instrumental activities of daily living)
- **Behavioral factors** – diagnoses, symptoms and information on functional status (short- and long-term memory capabilities, expressive and receptive language capabilities, visual challenges, psychomotor challenges, and executive function)
- **Personal** – personality traits, relevant cultural values, health literacy, coping styles, interests, preferences
- **Social** – primary support, social environment, and issues related to financial, housing, legal, and transportation factors

The care team is instructed to think broadly and creatively, listing anything under each factor that could be relevant. The team goes "around the Star" assessing and highlighting which of the elements listed on each point might be significantly connected with, and thus contributing to, the challenge in the middle of the Star. The process also reveals if there are potentially relevant data that might be missing that the care team will need to inquire about.

Simply getting the factors on paper in one place is often enough for the care team to identify unnoticed patterns or clues. Furthermore, the act of joining in this systematic exercise as a team creates an opportunity for care team members to identify new connections across factors, clearly identify the primary challenge, and generate novel solutions. The tool's creator, Dr. Howell, notes that it's simply not possible to do the same kind of analysis of complex situations "by attempting to keep all the data in one's head."[3] In this way, the Wisconsin STAR method, described by its creator as a "low-tech" solution, enables teams to solve complex challenges.

[2] Wisconsin Geriatric Psychiatry Initiative (WGPI). Information Domains for Use with the Wisconsin Star Method: Information helpful to gather – as feasible, but not required. Retrieved from https://wgpi.wisc.edu/wordpress/wp-content/uploads/2016/04/WiStarMethodChecklist2016.pdf.

[3] Howell, T. (2015). The Wisconsin star method: understanding and addressing complexity in geriatrics. In *Geriatrics Models of Care* (pp. 87-94). Springer, Cham.

Wisconsin STAR Method in Action at Care Wisconsin

Care Wisconsin adopted the Wisconsin STAR Method three years ago and has continued to adapt it to their needs with input from care team members. They found the following elements to be helpful for successful use:

- **Distribution of the STAR Method template to care team members prior to the meeting**: While an 'overall' STAR is created collaboratively during a care team meeting, having individual copies of the template for each team member (either printed or on their personal computer) allows them to easily record their notes for each potential factor before and during the meeting, which encourages active participation from each care team member.
- **Use of both virtual and in-person care team meetings:** Care Wisconsin staff introduced a live screenshare platform that allowed for real-time completion of the STAR Method template by care team members working at different locations. This opened up attendance to additional members of the care team, broadening the discussion of root causes and proposed solutions.
- **Clear time allotments for components of STAR Method meetings:** Care Wisconsin found that initial meetings were exceeding set times and not wrapping up with action items. They found it helpful to allot an hour and a half for discussion of factors and root causes related to each member, and to then devote 30 full minutes to planning next steps and identifying appropriate solutions. The new meeting process ensured that this critical wrap-up activity was not rushed. Depending on the complexity of the member's situation, the care team might schedule follow up meetings to review progress.

By using the Wisconsin STAR Method, Care Wisconsin has been able to better support its members by gaining a more holistic perspective on the interacting factors affecting health and well-being. Care Wisconsin is performing utilization analyses to assess measures associated with the implementation of the Wisconsin STAR Method. Their current focus has been on member specific outcomes post-Wisconsin STAR consult, and they are in the process of compiling results. For more information about adopting the Wisconsin STAR Method, contact Jeff Wobig, Senior Director Program Operations at Jeff wobigj@carewisc.org.

Wisconsin STAR Method in action

Example 1: A member was visiting the ED 2-3 times per week. The care team identified that the member felt isolated from her cultural community and was visiting the ED to talk with individuals who worked there who were also of Indian descent. The care team worked with the member to change her housing placement to a community-based residential facility run by an owner of Indian descent that served the food she was familiar with and that provided a more culturally aligned experience. The member built trusted relationships with the staff who in turn were able to assist her in developing relationships with other residents. The member's ED visits were significantly reduced.

Example 2: A member with severe and persistent mental illness was repeatedly visiting new mental health providers. As a result, the member did not have a consistent provider for receiving prescriptions and support, did not take medications as needed, and repeatedly required county crisis interventions. The care team identified a significant trauma history that led to the member having difficulty trusting providers. The care team worked to engage the member with a provider who practiced trauma informed care. The member was able to establish a longer-term relationship with a provider, leading to stable access to needed medications and counseling that increased the member's quality of life and significantly reduced the need for county crisis interventions.

The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) seeks to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. This spotlight is intended to support health plans and providers in integrating and coordinating care for dually eligible beneficiaries. It does not convey current or anticipated health plan or provider requirements. For additional information, please go to https://www.resourcesforintegratedcare.com/.