Summertime Skill Series: Sunshine, Summer time, and Smart Goals

SESSION 2: JULY 14TH

Review of Session 1:

- Great Feedback/Suggestions/Questions!!
- Regulations and Requirements: DHS= Person Centered CMS= Clinical Focus
- Why do we need SMART Goals?
- Introduction to Writing SMART Goals, and how to tell if a goal is SMART

Questions/Clarifications from Session 1:

- Member's name or I?
- Would like vs. I want
- 1 High Priority Goal is required on CCP
- Goals matching the services authorized

Todays Session Agenda:

- ❑Care Planning for Assessed Needs
- ❑Motivational Interviewing
- ❑Unrealistic Goals/Members who have difficulty identifying Goals
- ❑Examples of Collaborative Care Plans with both SMART Goals and not-SMART Goals
- ❑Case Study/SMART Goal Practice
- ❑Questions

Care planning for assessed needs- What are the requirements?

- Identified needs and concerns related to primary care, acute care, long term care, mental health, behavioral, and social service needs and concerns are *addressed on the care plan*
- If a risk and or issue is identified in the HRA and not addressed in the Care Plan; *documentation needs to be present as to the reason why* i.e.: Member choice, refusal etc.

Essential Services:

- Services that are essential to health and safety of the member must be documented
- If essential services are included in the plan, a back up plan for provisions of essential services is documented

Essential Services Backup Plan: *(when providers of essential services are unavailable; essential services are services that if not received, health and safety would be at risk)*

I am receiving essential services ☑ Yes ☐ No

Essential services I am receiving: Skilled nurse setting up medications weekly

If Yes, describe provider's backup plan, as agreed to by me:

If nurse is unable to set up medications, my daughter will assist until nurse is available.

Informal and Formal Services:

- The member must receive a description of their formal and informal services
- If you have identified an assessed need in the LTCC and the service was offered but declined **OR** accepted it should be carried over to section K of the LTCC and to the support plan portion of the care plan. These should match.
- Type of service, Amount, Frequency, Duration, Cost, Type of provider (including non-paid care givers and other informal community supports)

Provider Name *address, phone, fax and contact person*	**Service Provided**	**Schedule/Frequency**	**Start Date/End Date**	**Units Cost and Total Cost per Month**
Genevive 952-210-0001	Care Coordination/Case Management	Every 6 months or as needed.	3/19/19 to 3/18/20	-----
Optage 651-746-8200 Fax: 651-746-8281	Home Delivered Meals	5 meals per week	4/15/19 to 3/31/20	$6.81/meal $147.55/month
Care Mate 651-659-0208 Fax: 651-659-0161	PCA	6 hours per day, 7 days per week (24 units per day)	10/01/18 to 9/30/19	$4.35/unit $3175.50/month

Comprehensive Care Plan Goals Audit Elements:

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.

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

- Goals and skills selected by the enrollee to be achieved are clearly described;
- 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;
- Plan for monitoring progress towards goals is included;
- Target dates for completion are included (at least month and year);
- Outcome/achievement dates are included;
- People/providers responsible for assisting the enrollee in completing each step are identified.

Tips & Tricks to Negotiate Goals:

- Break long-term goals into steps
- Prioritize by importance, put “first things first”
- Identify a complementary or supportive goal to the primary goal
- Respect the individual’s preferences
- Defer to the goal stated by the individual when there is unresolvable conflict (with the family or the organization)
- Continue to educate and encourage goals that have the potential for positive health and quality-of-life outcomes

Motivational Interviewing: its all about eliciting change

4 General Principles of Motivational Interviewing:

- Expressing Empathy
- Recognition of Discrepancy
- Rolling with Resistance
- Supporting Self-Efficacy

Expressing Empathy: Conveying understanding of the clients perspective and acceptance of their situation

Active Listening

Open ended questions

Affirm the client

Reflective Listening-state what your heard the client say

Summarize the clients conversation

Reflective Listening

It sounds like..

Is seems as if..

I get a sense that..

It feels as though..

Help me to understand..

Recognition of Discrepancy: Working with the member to identify the difference between current and future states and recognize goals to be achieved

Eliciting	**Selective Reflection**
Purposeful questions that influence the client to bring forth a thought, emotion, or concern into existence that otherwise would have remained hidden.	Paraphrasing specific things the client says or does to influence discussion about the desire to change, the ability to change, and reasons for making the change.

Roll with the resistance: Allowing the member to verbalize resistance to change and share the experienced concerns or challenges.

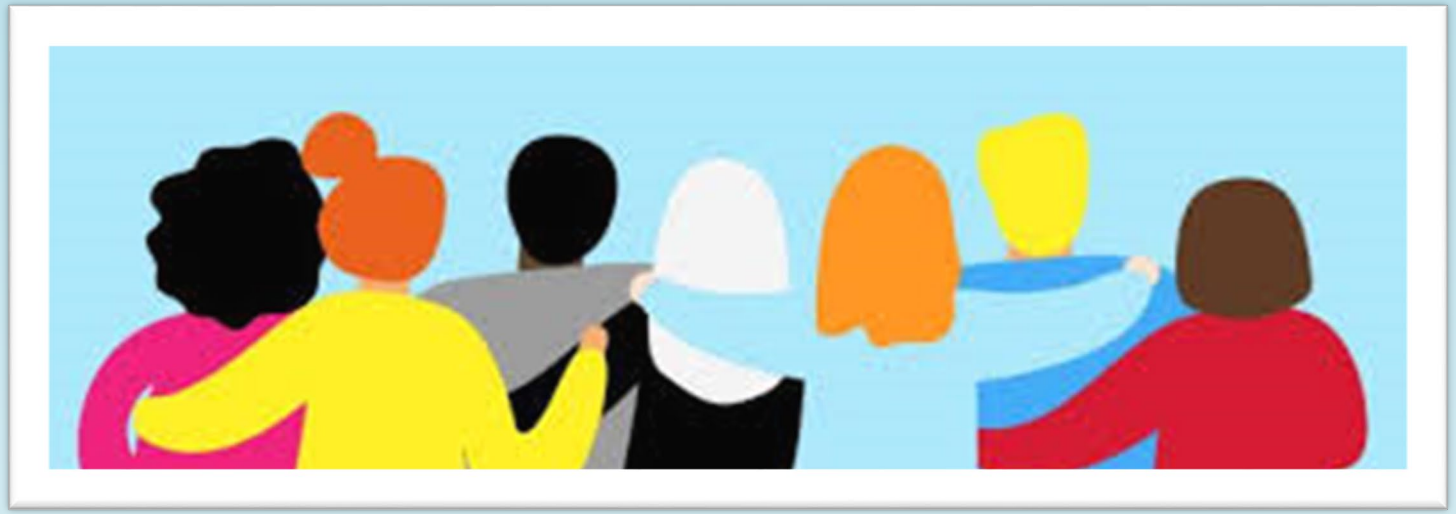
Accepting

Acknowledging a situation without attempting to change it, judge it, or protest it

Respecting Autonomy

Respecting the clients right and capacity to choose whether to change or not and allowing the member to change at their own pace

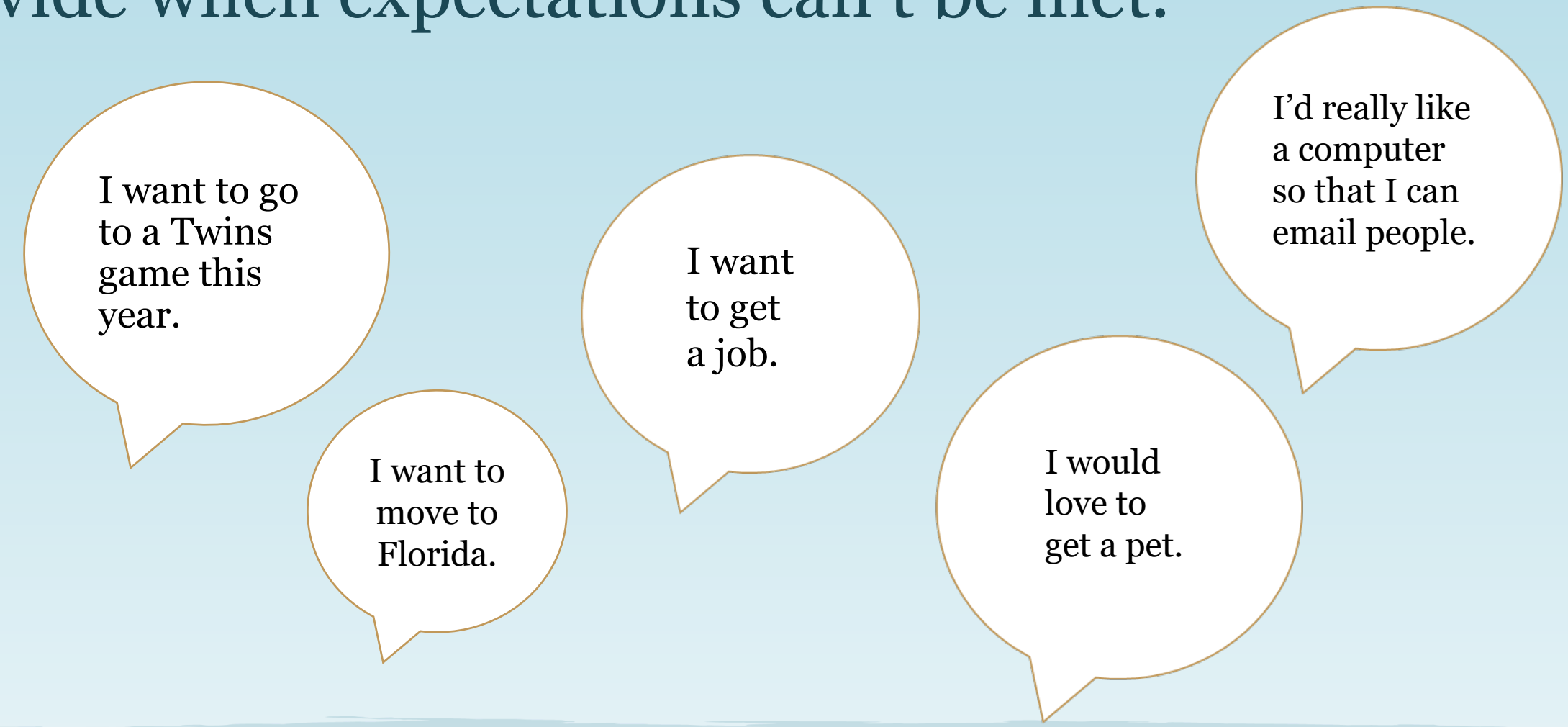
Support Self-efficacy: Affirming the members successes and achievements despite how small they may be.



Enhancing: Summarizing what the client has said over time

Affirming: Voicing support for the clients strengths and change efforts

Unrealistic Goals and Navigating the pressure to provide when expectations can't be met.



Addressing goals with members who have difficulty identifying goals:

- Avoid directly asking members to list out their goals. Instead of asking a member: “What are your personal goals? Try: “Lets talk about your personal and health goals” and maybe add in a question from below.

- Other questions to try:
- How would you like your life to be different?
- What does your health condition keep you from doing that you would like to do?
- How is your health interfering with your quality of life?
- What do you enjoy doing? What would you like to do more of, or less of?
- What makes your life more satisfying to you?

Case Example: Artie

Artie is a 41 year old male who lives in an apartment with his girlfriend. His diagnosis include bipolar disorder and diabetes. This is your 3rd year seeing Artie who has been relatively stable. Every time you have asked Artie “What are you health goals for the year? he shrugs his shoulders and says “I don’t know, I’m pretty good just the way things are.”

Possible Questions to ask Artie to elicit some goals:

What makes you happy, what do you enjoy doing?

When we were talking about your preventive health, you mentioned that you haven’t been to the dentist, would this be something you would be willing to work on over the next year?

Collaborative Care Plan Example

Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☒ Medium ☐ High	I will talk to my therapist about my dental fears by our next review..	Care Coordinator to offer support and encouragement.	12/1/20	9/1/2020: TC to member for goal review. Member did speak with his therapist who suggested a prescription for anxiety medication before visit	9/1/2020

Collaborative Care Plan Examples

Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☐ Medium ☒ High	1. Medical: I will manage my health conditions of diabetes, HTN, obesity and pain and will follow the recommendations for preventative care including: -Annual Wellness Exam -Annual Eye Exam -Annual Dental Exam -Discuss the benefits of taking Calcium with Vitamin D, pneumovax and cancer screenings with my doctor. -Take medications as prescribed -Discuss evaluation of incontinence	A. I will schedule appointments and lab tests with my physician as recommended. B. I will take medications as prescribed and update physician of any adverse effects with the help of my daughter. C. I will monitor my Blood Pressure and Blood Sugar and report consistent changes to physician. D. My Care Coordinator has explained health coaching programs to me. E. I will use Provide a Ride transportation to access the clinic and contact my care coordinator to assist me with appointments as needed.	03/18/20	9/06/19: Member reassessed. Health concern remains a primary one for member. Goal is to lose weight and be able to maintain her mobility. Health goal carried over to new care plan.	9/06/19: Ongoing

Collaborative Care Plan Examples

VII. My Goals

Discuss with Care Coordinator goals for: my everyday life (taking care of myself or my home); my relationships and community connections; my future plans, my health, my safety; my choices.

Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☐ Medium ☑ High	I will manage my diabetes	CC will provide me with list of providers for diabetic testing strips I will complete diabetic testing as instructed by PCP I will have labwork (HbgA1c) completed quarterly I will schedule eye exam I will schedule a visit with the foot doctor CC will provide me with list of diabetic educators I will schedule an appointment with the diabetic educator Skilled nurse will set up medications weekly I will take my diabetic medications as ordered	2/6/18	2/16/17 Mailed member list of providers for diabetic testing strips & diabetic educators 4/1/17 Skilled nurse setting up member medications, reviewing blood sugars. Member taking medications as set up and blood sugar #'s from 100-135 4/5/17 HbgA1c=8.2, medication was increased 4/20/17 Met with diabetic educator, discussed nutrition and exercise, importance of testing at same time. Verified member has been able to get testing strips and is testing as ordered by PCP. 5/12/17 Eye exam completed 6/26/17 Foot exam completed, recommendation for diabetic foot	2/1/18 Goal ongoing, carried forward to new care plan.
☐ Low ☐ Medium ☑ High	I will complete an annual physical	I will contact clinic and schedule annual physical	6/1/17	4/8/17 Annual physical completed with Dr. Smith	4/8/17 Achieved
☐ Low ☐ Medium ☑ High	I will use provide a ride for transportation to medical appointments	CC will provide me with PAR phone number I will contact PAR and schedule medical transportation I will contact my CC if problems arise with scheduling medical transportation	2/6/18	4/20/17 Member was able to utilize PAR independently for medical appointments and diabetic supply pickup.	2/1/18 Goal ongoing, carried forward to new plan
☐ Low ☐ Medium ☑ High	I will not have an injury from a fall	CC will educate on fall risks CC will educate on benefits of Lifeline I will carry my cellphone everyday	2/6/18	2/16/17 Member declines lifeline 4/20/17 Member reports that she is carrying cell phone daily. Daughter reports that there have been no falls and member has contacted her if she feels dizzy.	2/1/18 Goal ongoing, carried forward to new care plan.

Collaborative Care Plan Examples

Not Measurable

☐ Low ☐ Medium ☑ High	I will manage my diabetes	CC will provide me with list of providers for diabetes testing strips I will complete diabetic testing as instructed by PCP I will have labwork (HbgA1c) completed quarterly I will schedule eye exam I will schedule a visit with the foot doctor CC will provide me with list of diabetic educators I will schedule an appointment with the diabetic educator Skilled nurse will set up medications weekly	2/6/18	2/16/17 Mailed member list of providers for diabetic testing strips & diabetic educators. 4/1/17 Skilled nurse setting up member medications, reviewing blood sugars. Member taking medications as set up and blood sugar #'s from 100-156. 4/5/17 HbgA1c 9.0, medication was increased. 4/20/17 Met with diabetic educator, discussed nutrition and exercise, importance of testing at same time. Verified member has been able to get testing strips and is testing as ordered by PCP. 5/12/17 Eye exam completed. 6/14/17 Had communication for diabetic foot	2/1/18 Goal ongoing, carried forward to new care plan.

SMART GOAL

Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☐ Medium ☒ High	I will self-report checking Blood Sugars as recommended by their physcian by the next review.	Skilled Nurse Visits every other week for teaching and monitoring of Diabetes	11/1/2020	9/1/20: TC to member who reports nurse visits going well. 11/1/ TC to member who reports Blood Sugar checks as recommended	9/1/20: Ongoing 11/1/20: Goal Met

Collaborative Care Plan Examples

Not Measurable

☐ Low ☐ Medium ☑ High	I will not have an injury from a fall	CC will educate on fall risks CC will educate on benefits of Lifeline I will carry my cellphone everyday	2/6/18	2/16/17 Member declines lifeline 4/20/17 Member reports that she is carrying cell phone daily. Daughter reports that there have been no falls and member has contacted her if she feels dizzy.	2/1/18 Goal ongoing, carried forward to new care plan.

SMART GOAL

Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☒ Medium ☐ High	I will self -report any falls to Provider, Caregivers, and Care Coordinator by next review..	Care Coordinator ordering Cane for member	12/1/2020	11/1: TC to member who reports that they are using the cane that was orderded and have not had any falls.	9/1/20- Ongoing 12/1/20- Goal Met

Case Study: Evelyn

Evelyn is a 92 year old female that lives with her daughter in her daughters home. Evelyn was diagnosed with Alzheimer's about 3 years ago. During the visit her daughter became tearful stating that she is exhausted and is needing more help, as her mothers forgetfulness is increasing. She is considering other housing options for her mom.

My daughter and I will look at 3 Memory Care Assisted livings by next review.

Care giver will attend 1 Alzheimer's support group per week by target date.

Caregiver will verbalize understanding of respite options by target date.

Collaborative Care Plan Examples

Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☒ Medium ☐ High	Caregiver will attend 1 Alzheimers support group per week by target date.	Care Coordinator to provide list of Alzheimers support groups in the area.	12/1/2020	11/1/20: TC to check in with daughter who states that she has been attending a local Alzheimers Association group weekly..	11/1:Goal Met

Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☒ Medium ☐ High	My daugther and I will look at 3 Assisted Living Facilities by the next review.	Care Coordinator to provide list of openings from Care Options Open Bed Report	12/1/2020	9/1/20: TC received from members daughter who states that an ALF as been found.	9/1:Goal Met

Case Study: Tran

Tran is a 75 year old Vietnamese male with the following conditions: DM and HTN. Tran does not speak English, and you have an interpreter with at the visit. Tran is also legally blind, and lives in his son's home where his daughter in law cares for him most of the time. There are hours during the day that he is alone which Tran states "worries him". Tran also tells you that he wishes he were less of a burden to his family. With the help of the interpreter you are able to come up with several ideas: PCA to assist with ADLS (dressing, bathing, grooming), and a Lifeline for the member when his family or PCA are not home, and an Occupational Therapy visit for a home safety evaluation to help set up his bedroom so that he is able to move around better.

Tran will self-report completion of a Home Safety evaluation by the next review.

Tran will accept PCA and Lifeline service by the next review.

Tran will verbalize feeling safe and content in his living environment by your next review.

Collaborative Care Plan Example

Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☒ Medium ☐ High	Tran will accept PCA (Personal Care Attendant) and Lifeline Service by the next review.	Care Coordinator to supply Personal Care Attendant) vendor list to member/family	9/1/20	9/1: TC to member who reports Lifeline has been set up and family/member have chosen and agency	9/1/20: Ongoing, Care Coordinator to assist member in contacting agency

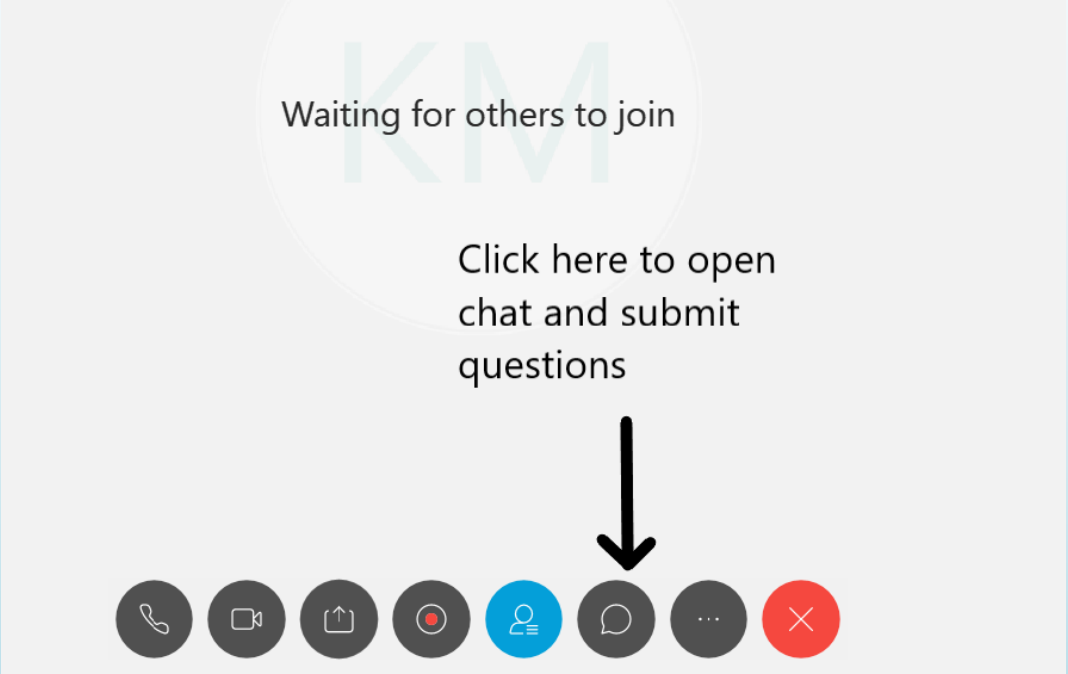
Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☐ Medium ☒ High	Tran will self-report completion of a home safety evaluation by the next review.	Care Coordinator to make referral to homecare agency for Home Safety Evluation.	9/1/2020	9/1/20: TC to member who reports that he did have an Occupational Therapist out a week ago to complete an evaluation.	9/1/20- Goal Met

Session 3 Preview

- SMART GOALs Example Guide Review
- SMART GOALS Resources
- Practice making generic goals into personalized goals
- Case Study and more practice.

Questions??

- Please use chat function in WebEx to send Questions
- For questions after this session you can reach out to me at: Kera.Morelock@Medica.com



References:

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