Division of TennCare

STATE OF TENNESSEE
THL WEBINAR

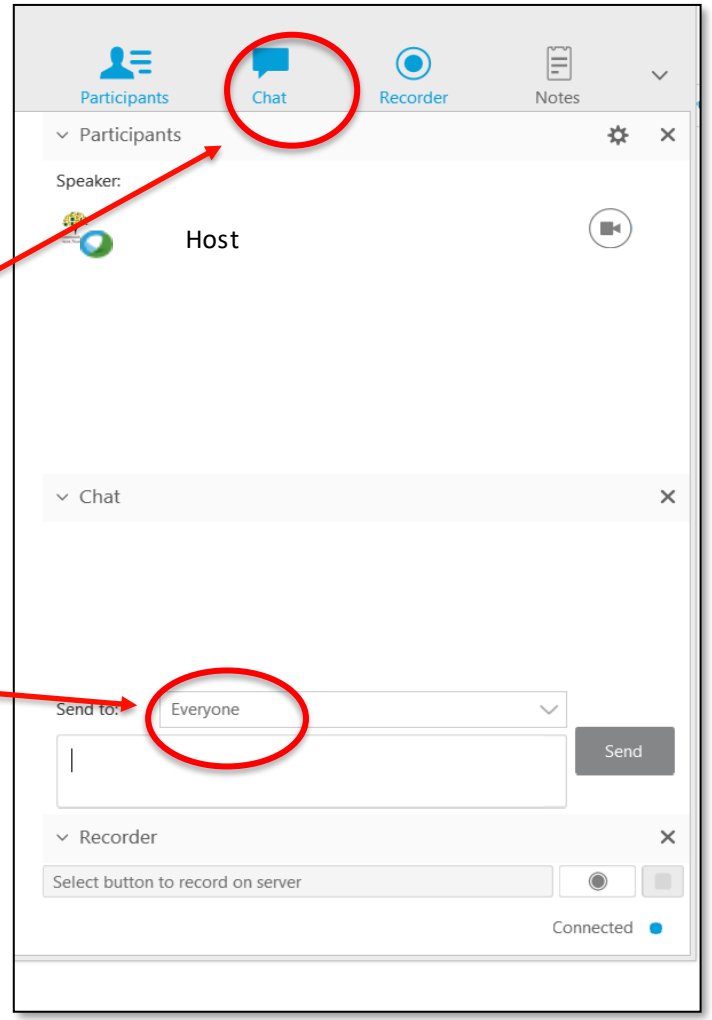
Person-Centered Care Planning

April 23, 2021

Interactive Webinar

Communicating during the webinar:

- For questions or comments during the presentation, please click on the **chat box** function
- Select “Everyone” and enter your question or comment
- This will also be used during all Q&A portions of the presentation



Agenda

- Welcome – Jasmine Randle, TennCare
- The Need for Care Planning
- Utilizing Assessments to Inform Care Plans Goals
- Education on Creating SMART Goals
- Clarifying Care Plan Updates
- Q&A Panel

SPEAKERS

Jill Amos, PH.D – BlueCare Tennessee

Barbara Risa Schwartz, BSN, RN, BC – UnitedHealthcare

Anne Dodd, MS, LBA, MBA – BlueCare Tennessee

Renee Darks, LPC/MHSP – Amerigroup

Jill I. Amos, Ph.D.

Principal, Behavioral Health Clinical Psychologist

Dr. Amos received her Bachelor's degree in Psychology at New Mexico State University in 1987 and her Doctoral degree in Counseling Psychology at Texas Tech University, completing her internship at the University of Tennessee Psychology Consortium in 1993. She has been licensed as a Psychologist and Health Services Provider in the state of Tennessee since 1995. She has worked in a variety of settings, including the Center for Children and Parents (LeBonheur Children's Hospital), in private practice, and as the Regional Psychologist for Departmental Children's Services in Shelby County. She has been employed as the Behavioral Health Psychologist with BlueCross BlueShield of Tennessee since April 2015.

Barbara Risa Schwartz

New Yorker born and raised, BSN from UT Knoxville. Have lived in the greater Knoxville area over 40 yrs.
37+ years of experience in Psychiatric nursing, 25 years in Inpatient positions from staff to administration, and 12 years with UHC in a variety of roles.

ANNE DODD

MS, LBA, MBA, Behavioral Health Quality Management Specialist

In her role, Anne is responsible for conducting THL Engagement and Evaluation Reviews for Middle Region providers and serving as a THL Quality Coach.

Anne holds a Bachelor of Arts degree in Psychology from Alabama A&M University in Huntsville, Alabama, a Master of Science degree in Applied Behavior Analysis from Jacksonville State University in Jacksonville, Alabama, and a Master of Business Administration degree from Lipscomb University in Nashville, Tennessee. She is also a Licensed Behavior Analyst who has extensive experience working with the IDD population for eleven years prior to coming to BlueCare.

Renee Darks, LPC/MHSP

Amerigroup Behavioral Health Care Consultant

Renee holds a Master's in Counseling from Trevecca Nazarene University. She is a Licensed Professional Counselor and has worked in the healthcare industry for over 25 years. Sixteen of those years were spent in a community mental health setting where Renee provided therapy services to individuals, families, and groups with an emphasis on trauma. Additionally, she was involved with case management and coordinated an Early Childhood Network program. She has been with Amerigroup for the past 8 years.

BlueCare Tennessee

DR. JILL AMOS

The Importance of Person-Centered Care Planning

In health and social care, a care plan is crucial to ensure that the member receives the right level of care and that care is given in line with their needs. Care plans are based on individual needs and are, consequently, different from person to person. Although each care plan is unique, they all serve the same purposes, which are:

- Helping the Member Set and Achieve Goals
- Team Collaboration
- Training and Supervision of Care Coordinators
- Addressing Barriers
- Monitoring Member Progress
- Reviewing Goals
- Focusing on Prevention
- Providing Crisis Information

Person-Centered Concepts

"The individual's goals should drive care coordination, but to be effective, person-centered care management also requires effective communication and coordination amongst the individual, their health care providers as well as paid and unpaid supports." – National Committee for Quality Assurance (NCQA)

Case Managers (CM) are responsible for coordinating health care services for members with the highest behavioral health needs. Case Managers must understand what is most important to the member.

Case Managers must also have an effective system for supporting individual preferences and goals when coordinating care with others supporting the member. The CM is often at the center of HOW that care is coordinated.

Knowledge Check

Golden Thread

- The Golden Thread is the consistent presentation of relevant clinical information throughout all documentation for a member. The Golden Thread **begins with assessments that clearly identify clinical & member needs.**

- The Care Plan should then set out a **clear series of Goals for helping the member through the identified concerns.** Each Goal should have specific Objectives identified that reflect best practices.

- Finally, the Golden Thread includes progress notes that demonstrate that the services you deliver match what was outlined in the Care Plan. Each note should lead into the next, creating a comprehensive story of the member's progress.

Person-Centered Care Planning

- It's approach and philosophy always puts the person first; the uniqueness of each person is identified, respected and honored.
- It promotes individual involvement, choice, and quality of life.
- Listening is crucial
- Builds a respectful, collaborative partnership with the member.
- What strengths and abilities does the individual have that could be leveraged to assist with reaching his/her goals?

"While understanding short and long term goals and priorities are important, the way in which each person wants to achieve those goals is equally important."

The Council on Quality and Leadership (CQL)

Member Assessment & Care Plans

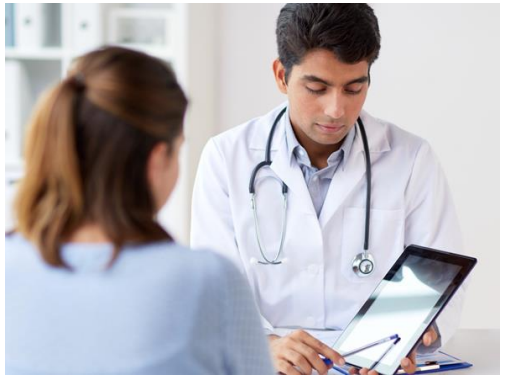
- Plans are guided/driven by the member's needs, based on functional & clinical assessments & other relevant data.
- Daily Living Assessment (DLA), Adult Needs and Strengths Assessment (ANSA), Care Coordination Tool-Admissions/Discharge/Transfers (CCT-ADT) and Quality Measures, MCOs Gaps in Care (GIC)
- Internal communications-MD/NP/Therapist/Other
- Clearly identifies primary, specialty, behavioral health, community and social needs. (Integrated Care/Care Coordination)
- Identifies the areas member needs support, including engaging members in care, promoting continuity of care & health promotion.
- Recognizes & utilizes member's strengths.
- There will be periodic reassessments, to identify progress re: meeting their goals, & then assessing & addressing changes in the member's needs.

Functional Assessment/DLA

- Needs to be completed every 6 months or earlier.
- Should **always** be completed prior to Care Plan Update.
- Is a primary resource for Goal identification/key piece of the Golden Thread
- Can use multiple higher need areas to drive your conversation with member.
- For members with chronic long-term needs, focus may need to be on specific areas where small steps can make a difference.
- Use discussion & your insights to prioritize Goals **with member-Shared Decision Making!**

Examples of Functional Needs

- Some needs score or rank high: Housing, significant medical concerns, major school issues, medication adherence; and clearly need to be addressed.
- Some areas are more important to the member and thus need to be addressed early on: financial, safety, **high anxiety, insomnia**.
- Some areas may be more obvious to you: communication, social, hygiene.
- Some areas may be of high need but the member does not want to address: smoking, family issues.
- Subsequent assessments may add new areas, can re-affirm initial ones that are still concerns & can highlight improvements, areas no longer in high need. And Care Plan needs to align!



Simple Member Example

- Mary Smith was seen for her first encounter by her Care Coordinator Joan. Mary has just begun Medication Management and Therapy. Joan spent 1 hour with Mary, which included completing the Functional Assessment (DLA) and the initial Care Plan.

- On the DLA, Joan scored Mary as a “3” on Health Practices, related to Mary’s report of high anxiety, insomnia, hallucinations, and frequent periods of intense crying.

- Mary told Joan she really needed help in those areas. Together they discussed what Mary had already tried and what Mary thought could be helpful. Joan added a couple of suggestions, and Mary agreed that those could be beneficial.

- Joan wrote the Care Plan which they reviewed together, and Mary was pleased with the Goals and activities listed, and she signed the Plan.

Establishing Goals/Objectives

Quality Care Plan Goals should:

- Be linked to the needs identified in the assessments/DLA
- Be comprehensive
- Include desired outcomes relevant to the presenting problems & symptoms & utilize client's words
- Have a clear Goal statement
- Include measurable Objectives (how will Care Coordinator & member know when an Objective is accomplished)
- Use client strengths and skills as resources
- Establish a time period: length of time & frequency for the actions
- Be tied to discharge and transition planning
- Barriers subsequently identified may become Goals/Objectives in updated Care Plan

Person-Centered Care Planning

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SMART Goals Objectives

Understand the SMART acronym and how to apply it in the care plan

Identify common pitfalls when creating SMART person-centered goals

Learn techniques to convert identified needs into SMART person-centered goals

Create a SMART person-centered care plan

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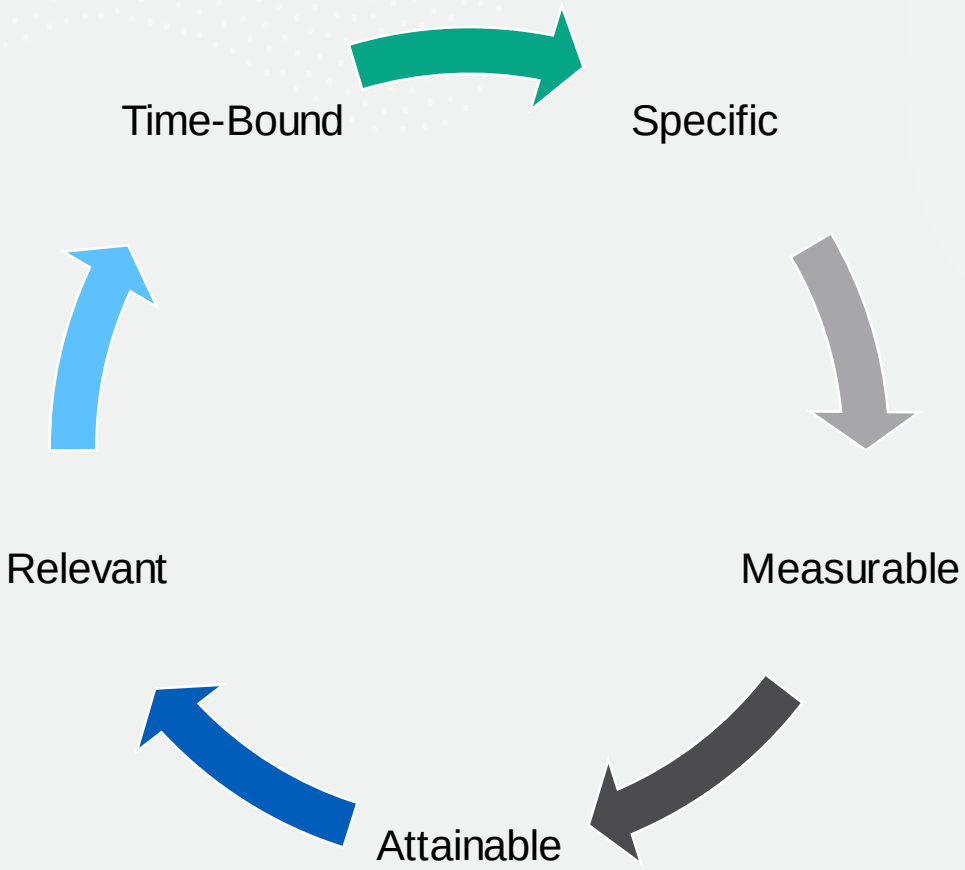
Developing SMART Goals



Pitfalls of Creating Goals

Members who aren't used to thinking in terms of goals may find this challenging.

Members focus on negative issues.

Member's desired goal may not be attainable or realistic.

Care plans may have too many goals.

Goals are "canned," not individualized, without member-specific supports or interventions listed.

Goals carried over from year to year may not be closely reviewed and updated.

Care plans may use abbreviations and clinical language that the member may not understand.

There may be barriers to achieving the goals.

Specific Goals

Specific: The goal/objective should be clear and highly specific, not general, vague or “cookie cutter” (some exact goals of everyone else).

“I would like to stay in my home.” – Not specific

Using Motivational Interviewing Techniques is a great way to elicit goals and get specific.

Eliciting a specific response, depending on the member’s circumstance, for the reason why they want to stay in their home is imperative.

Examples of Motivational Interviewing Questions:

“Help me understand why you would like to stay in your home.”

“What do you think you would lose if you don’t stay in your home?”

“Allow me to make sure I am following you correctly on why you want to stay in your home.”

Definition of Measurable, Attainable, Relevant Time Bound Goals.

Measurable: Objectives need specific times, amounts or dates for completion so you & your members can measure progress.

Attainable/Achievable: Your goal also needs to be realistic and attainable to be successful. In other words, it should stretch your abilities but still remain possible.

Relevant: The goal/objective should be pertinent to the issues identified. The goal also needs to matter to the member. If goals/objectives aren't significant to the member, they can easily be discarded

Time-Bound: Every goal must have a target end date/deadline. Goals might be considered short term or long term, while objectives need to meet specific dates. Deadlines help make goals feel more concrete because they attach them to a specific timeline, which decreases procrastination.

Smart Goal Example

Rank by Priority	My Goals	Support(s) Needed	Start Date and Target Date
○ Low X Medium ○ High	Mary would like to improve her mental health by sleeping four to six hours each night.	› Mary will take sleep aid medication as prescribed. › Mary will go for daily walks to help with her sleep. › Mary will not drink coffee past noon. › Mary's CC will provide information on mental health supports and coordinate care as needed.	Start Date: 05/21/21 Target Date: 11/21/21

Goal Creation: Tips &Tricks

- Help the member break down broad or vague statements into attainable goals.
- Craft the goal so that it expresses what the member wants yet meets requirements.
- Encourage goals that have the potential for positive health and quality-of-life outcomes.
- Promote self-advocacy and self-realization. Help the member find their “can do” attitude. Remind them: “You are your best advocate.”
- Identify and address barriers. Avoid clinical language and acronyms (PCP, CC, PRN, CHF, SNV, HHA, etc.).

Amerigroup

An Anthem Company

Modifying Care Plans

April 23, 2021

Knowledge Check

Revising the Care Plan

Modify Plans

- Following a request from the member
- Based on changes to the member's circumstances, function, or priorities
- Reflecting achievements and outcomes
- At least every 6 months

Transition

- Significant steps towards recovery and resiliency achieved
- Ready for discharge

Updating the Care Plan – The Golden Thread

Reference the Care Plan when meeting with the member

Review medical or school records, check for new diagnoses or changes in providers

Review progress, or lack of, with the member at each contact

Complete a new Functional Need Assessment to help determine areas of need to develop a Care Plan

Document discussions in the progress notes

- Speak to progress
- Speak to the goals and current state
- Include plan for next steps in progress notes

Revising the Care Plan

The existing care plan should be used to guide the conversation

Remove goals that are no longer relevant

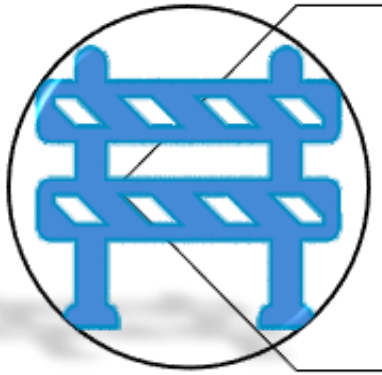
What progress has the member made and is that documented in the notes?

Adding new goals

Consider the most current functional needs assessment, changes in circumstances, and priorities.

Revising the Care Plan

Updating the care plan may be more than adding or removing goals



Address barriers

Where is there lack of progress and what action steps can be developed to address barriers?

Modify goals that are on-going

Are existing goals being addressed and is there is documentation to support what is being done?

Revising the Care Plan

SMART Goal Example – Initial

Goal

- Member will complete Diabetic Eye Exam

Objectives

- Member will call MCO and obtain list of nearby eye care professionals within 30-60 days
- Member will identify eye doctor and schedule appointment within 60-90 days
- Member will attend eye exam appointment within 90-120 days

Interventions

- CC will provide education material regarding diabetic eye exam within 30-60 days
- CC will provide list of eye care professionals within 60 days

Revising the Care Plan

SMART Goal Example – Modified

Goal

- Member will complete Diabetic Eye Exam

Objectives

- Member will reschedule eye exam appointment within the next 30 days
- Member will add eye appointment to calendar and store on the fridge as a visual reminder and check daily
- Member will ensure transportation is scheduled at least 2 weeks prior

Interventions

- CC will work with member on ensuring transportation is scheduled at least two weeks prior to the appointment
- CC will call to remind member of appointment at least 3 days before the appointment
- CC will follow up with eye care professional and verify member attendance within 30 days of the scheduled appointment

Take-aways

- Collaborative approach with the member in the driver's seat
- SMART goals which create a living document.
- Utilize care plan each contact with the member
- Goals are removed, added, or modified at least every 6 months or as the member's circumstances change-reference new functional needs assessment
- Identify and plan for barriers, make modifications to goals to reflect this, then monitor for the next steps
- Show evidence of The Golden Thread
- Documentation paints the picture of the member's progress or lack of progress

Q & A

Thank You

Appendix

RESOURCES

- https://www.healthit.gov/sites/default/files/nlc_shared_decision_making_fact_sheet.pdf
- https://www.ncqa.org/news/person-centered-care-planning-identifying-goals-and-developing-care-plans/
- https://www.tn.gov/content/dam/tn/tenncare/documents2/HealthLinkWebinarComprehensiveCareManagement.pdf
- Internet Citation: Putting Care Coordination and Care Plans Into Action. Agency for Healthcare Research and Quality (AHRQ). https://www.ahrq.gov/ncepcr/care/coordination.ht
- SAMHSA- Center for Integrated Health Solutions. Care Planning and Documentation in Integrated Health. National Council For Community Behavioral Healthcare. www.integration.samhsa.gov
- Motivational Interviewing listed at the tn.gov website: **THL→ Conference Materials→*Navigant Conference July 2017, Motivational Interviewing Session***
  https://www.youtube.com/watch?v=hyZpvJbh2FY
- TennCare THL site:
  https://www.tn.gov/tenncare/health-care-innovation/primary-care-transformation/tennessee-health-link.html