# The Art & Science of Creating SMART Person-Centered Goals

Presented by the Health Plan Collaborative Workgroup

October 26th, 2018

MEDICA®

# Health Plan Collaborative History

- Self initiated workgroup that began working together in February of 2007
- Collaborative Efforts:
  - Collaborative Care Plan and Instructions
  - Transitions of Care Log/Process
  - Provider Signature Requirements
- Audit planning for consistent process across health plans
- Partnering with DHS regularly for statewide training and other new initiatives

# Your Presenters

Kim Flom-Brooks, Partner Relations Consultant (Blue Plus)

Melissa Rakow-Pare, Partner Relations Consultant (Blue Plus)

Sue Oestreich, Senior Manager of MSHO/MSC+ and SNBC (HealthPartners)

Jenny Lanoue-Glerum, Clinical Improvement Lead (Medica)

Leah Roell, Care Coordinator (PrimeWest)

Becky Ziller, Care Systems Manager (South County)

Julie Steiner, Care Management Supervisor MSHO/MSC+ (UCare)

# Objectives

- Understand the SMART acronym and how to apply it in your care planning practice
- Learn techniques to convert identified needs into SMART person-centered goals
- Identify common pitfalls when creating SMART person-centered goals
- Create a SMART person-centered goal

# Policy Drives Person-Centered Approaches

CMS and DHS

- Americans with Disabilities Act (ADA) and the Olmstead decision
- Minnesota's Olmstead Plan
- CMS Home and Community-Based Services Rules
- Minnesota Statute 245D

# 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)

- Moving from provider-centered instruction to person-centered participation
- Care Coordinators (CC), responsible for helping individuals with their medical and long-term service and support (LTSS) needs, must understand what is most important to the person
- CCs must also have an effective system for supporting individual preferences and goals when coordinating care with others supporting the individual. The CC is often at the center of <u>HOW</u> that care is coordinated.

# Pitfalls of Creating Goals

- Members who are not used to thinking in terms of goals may find this challenging
- Members focus on negative issues
- Members desired goal may not be attainable or realistic
- Care plans have too many goals
- Goals are ‘canned’, not individualized, without member specific supports or interventions listed
- Carrying over goals from year to year without close review and updating
- Using abbreviations and clinical language that the member may not understand
- There may be barriers to achieving the goals

# Developing SMART Goals

SMART goal development was developed by George T. Doran

- Specific
- Measurable
- Attainable
- Relevant
- Time-Bound

# Writing a SMART Goal:

**Specific:**

State the goal clearly; use a person-centered statement

"I would like to stay in my home"

Using Motivational Interviewing Techniques is a great way to elicit goals and get **Specific.** Care Coordinators need to help members articulate their goals.

# Writing a SMART Goal:

## **Measurable:**

| What | How Measured |
|---|---|
| Smoke no more than 10 cigarettes per day | Self report |
| Improve mental health by sleeping 4-6 hours/day | Self report |
| Congestive Heart Failure to remain stable by not gaining more than 5 lbs in 3 days | Clinic records; self report |

# Measurable Goal:

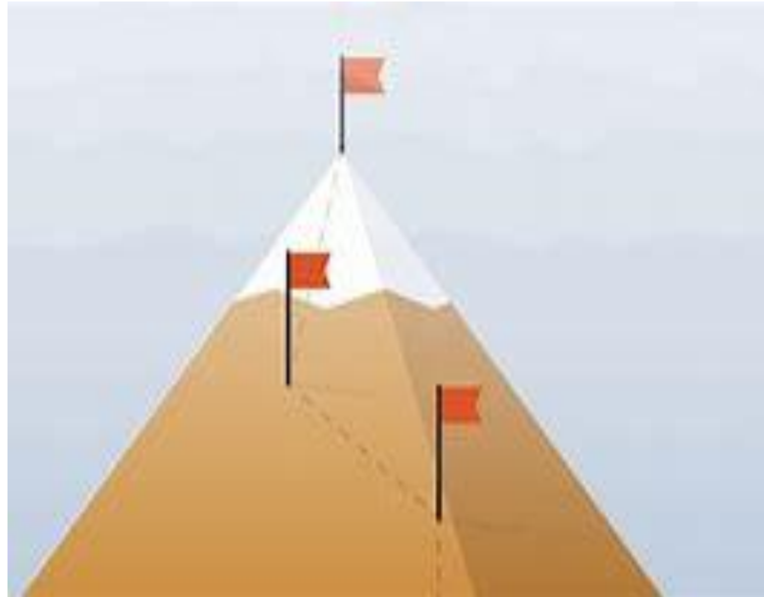
| Rank by Priority | My Goals | Support(s) Needed | Target Date |
|---|---|---|---|
| ☐ Low<br>☒ Medium<br>☐ High | Sam would like to improve his mental health by sleeping at least 4-6 hours per night | -Sam will take sleep aid medication as prescribed.<br>-Sam will go for daily walks to help with his sleep.<br>-Sam will not drink coffee past noon<br>-CC will provide information on mental health supports and refer as needed. | 9/30/19 |

Measurable Goal

# Writing a SMART Goal:

**Attainable**:

Break the goal into smaller, actionable steps. Identify expected barriers and make a plan to address them.



# Not attainable – attainable goal

| Not attainable | Attainable |
| --- | --- |
| I want to be smoke free | Sam would like to smoke no more than 10 cigarettes per day |

# Attainable goal with supports

| Rank by Priority | My Goals | Support(s) Needed | Target Date |
|---|---|---|---|
| ☐ Low<br>☐ Medium<br>☒ High | Sam would like to smoke no more than 10 cigarettes per day | -Sam wants to schedule an appointment with his doctor about smoking cessation aids.<br><br>-Care Coordinator will provide information on health plan's smoking cessations programs.<br><br>-Sam will take over-the-counter products or medication as prescribed by his doctor.<br><br>-Sam will go for daily walks to feel healthier | 9/30/19 |

Attainable Goal

Actionable Steps

# Writing a SMART Goal:

**Relevant**:

Make sure the goal reflects what's important to the individual. Use Motivational interviewing to help tie identified needs from the assessment to goals.

- Why is this goal important to the member?
- How will this goal benefit your member?
- Will the member stay committed to the goal?

# Writing a SMART Goal:

**Time-Bound:**

Define the period in which the goal is to be attained and agree when to check progress.

- Is this a long or a short term goal
- Prioritize by importance, put “first things first”
- Schedule the time to follow up reviewing progress
- Are there things that could prevent goal from being completed

# PrimeWest Health

**My Goal**

Priority*

Low

Target Date

02/01/2019

My Goal*

This field is required

Support Needed (Intervention)

Progress Notes

Note

Goal Status Date

MM/DD/YYYY

Status

-- Select One --

Barriers to Meeting My Goal

| Barriers |
|---|
| Cognitive impairment |
| Court Order |
| Cultural and spiritual beliefs |
| Hearing impairment |
| Inadequate support system |
| Lack of understanding of a condition/health literacy |
| Medical complications |
| Noncompliance |

Add >

Add All »

< Remove

« Remove All

| My Barriers |
|---|
| Financial or insurance issues |
| Lack of motivation |
| Language or literacy |
| Transportation |

# Health Partners

HealthPartners®

**Date:** 8/5/2018

**Health Condition(s):** back pain, osteoporosis, osteoarthritis

**Member Goal:** John would like to self-report a pain level of ‘2’ or lower.
**Goal Target Date:** 2/28/2019. Goal will be evaluated in 5-6 months

# Collaborative care plan

**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<br>☐ Medium<br>☐ High | | | | | |

# Supports and Interventions

- Document any intervention(s) related to achieving the goal
- What will the member need to accomplish the goal
- Who will help the member achieve the goal
  - Formal/informal supports
- Can have multiple interventions for one goal

# Supports and Interventions Examples

- Sam’s daughter will remove scatter rugs throughout the house
- Sam’s sister will attend doctor’s appointments with him
- Sam’s home care nurse will visit weekly to fill his medication dispenser
- Sam will use a safety pendant to alert family if he falls
- Sam will schedule an appointment with a dietician at his clinic to discuss nutrition and meal plan
- Care Coordinator will provide smoking cessation information and mail to Sam

# Goal Creation: Tips and Tricks

- Build trust
  - Respect the individual’s preferences
- Listen for cues i.e. excitement about a topic, comments about current struggles or reflections on the past
- Motivational Interviewing techniques
  - Open ended statements
  - Reflective statements
  - Summarize
- Use Person-Centered language including:
  - Members name or I statement.  Refrain from using “Member”
  - Would like to, wants to, etc.  Refrain from using “will” or “should”

# Goal Creation: Tips &Tricks

- Gather information from the Health Risk Assessment to prompt a goal
- Help the member break down broad or vague statements into attainable goals
- Being able to craft the answer to express what the member wants yet meet 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. "You are your best advocate"
- Identify and address barriers
- Avoid Clinical language (PCP, CC, PRN, CHF, SNV, HHA, etc.)

# Pulling it all together

# Not SMART vs SMART Person Centered Goals

| Not Smart or Person Centered Goals | SMART Person Centered Goals |
|---|---|
| Member will stay living in his home | Sam would like to stay living in his home over the next 12 months |
| Member will lose weight | Sam would like to lose 15 pounds within the next 6 months |
| Member will be compliant with high blood pressure medications daily | Sam would like to take his high blood pressure medication every morning for the next 12 months |
| Member will be free from falls | Sam would like to be free from falls for the next 6 months |

# Case Example

Mildred is a 78-year-old female living in an assisted living facility and receives 24 hour customized living services. She is on the MSHO program and receives Elderly Waiver services through her managed care organization. You have been her care coordinator for two years and have a good and trusting relationship. She was recently hospitalized after a fall in her apartment resulting in a hip fracture. The staff at the assisted living tell you that Mildred tripped on a pile of papers. Mildred is scheduled to return to the assisted living after a 3 week stay at a Transitional Care Unit (TCU).

# Case Example

A reassessment is required due to a significant change in condition. Here is some information to consider during the assessment:

- The staff have been concerned about the long-standing clutter in Mildred's apartment and have had multiple conversations about it with Mildred and her family. During Mildred's rehab stay, the assisted living considered giving Mildred a 30-day eviction notice due to the unsafe living conditions her clutter causes.
- The assisted living staff is also concerned that Mildred now needs assist of one for all transfers and feel they will have difficulty meeting this need. Mildred has shown progress during her TCU stay.
- Other diagnosis: Dehydration, depression; chronic pain, osteoarthritis; obesity; hip fx with generalized weakness post discharge.
- Mildred self-administers meds but is not always consistent with taking them as scheduled.
- Mildred has 3 children; her oldest daughter is the most involved and is the POA for her. Mildred's son is also involved, however is opinionated about the care she receives.

# Summary of assessment discussion

- Daughter present at the assessment
- Mildred has identified that she wants to keep living in her apartment
- Mildred is motivated to clean up her apartment but feels that her depression and pain from arthritis get in the way
- She is weak after the hospitalization
- The doctor expressed concern over her weight and indicated that weight loss would improve her pain and mobility
- Son feels she would be safer in a nursing home
- Daughter is involved and visits weekly

# Exercise of writing goals and interventions

- Create a SMART Person-Centered goal
- List at least 2 interventions to support the goal
- Based on the member scenario
- Come back as a large group to share some examples

# Conclusion

- Establish a relationship with the member
- Determine what the member identifies as needs
- Develop SMART and Person-Centered goals
- Identify actionable supports and interventions
- Avoid pitfalls
- Use Tips and Tricks

# Resources

- Minnesota's Olmstead Plan http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_home
- DHS Person-Centered Practices site: https://mn.gov/dhs/partners-and-providers/program-overviews/long-term-services-and-supports/person-centered-practices/

# References

- The National Committee for Quality Assurance (NCQA)

  Goals to Care How to keep the person in “person-centered”

https://www.ncqa.org/wp-content/uploads/2018/07/20180531_Report_Goals_to_Care_Spotlight_.pdf

# Presenter contact information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|---|---|
| Kim Flom-Brooks, Blue Plus | kim.flom-brooks@bluecrossmn.com |
| Melissa Rakow-Pare, Blue Plus | melissa.rakow-pare@bluecrossmn.com |
| Sue Oestreich, HealthPartners | Susan.D.Oestreich@HealthPartners.com |
| Jenny Lanoue-Glerum, Medica | jenny.lanoue-glerum@medica.com |
| Leah Roell, PrimeWest | leah.roell@primewest.org |
| Becky Ziller, South County | Bziller@mnscha.org |
| Julie Steiner, Ucare | jsteiner@ucare.org |

# THANK YOU!