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

Session 3: July 29th

# Session 2 Review:

- Again Thank you for all of your Feedback/Suggestions/and Questions!
- Care planning for Assessed Needs
- Examples of SMART Collaborative Care plan and not-SMART
- Case Study/SMART Goal Practice
- Questions/Comments

# Questions/Clarifications from Session 2

- I will self-report
- Number of Goals
- Target Dates and follow-up requirements

# Session 3 Agenda:

- Case Studies
- Updating goals to make them SMART
- SMART GOALs Example Guide review
- Other Tools and SMART GOALS resources
- Questions?

# Case Study 1: Sandra

Sandra is a 32 year old SNBC member who has schizophrenia and is also diabetic.  When you ask about how she's been doing, she states that she struggles with staying organized and she frequently misses scheduled appointments with her providers. At the end of the assessment you circle back and say to the member You stated that you have difficulty staying organized and miss appointments, would this be something you would like to work on over the next year? At first the member was unsure, but after the Care Coordinator discussed how an ARMHS worker could help her to develop some ways to stay organized and attend scheduled appointments, the member agreed.

Possible Goals:

Sandra would like to report to her care coordinator attendance to all of her scheduled appointments this year.

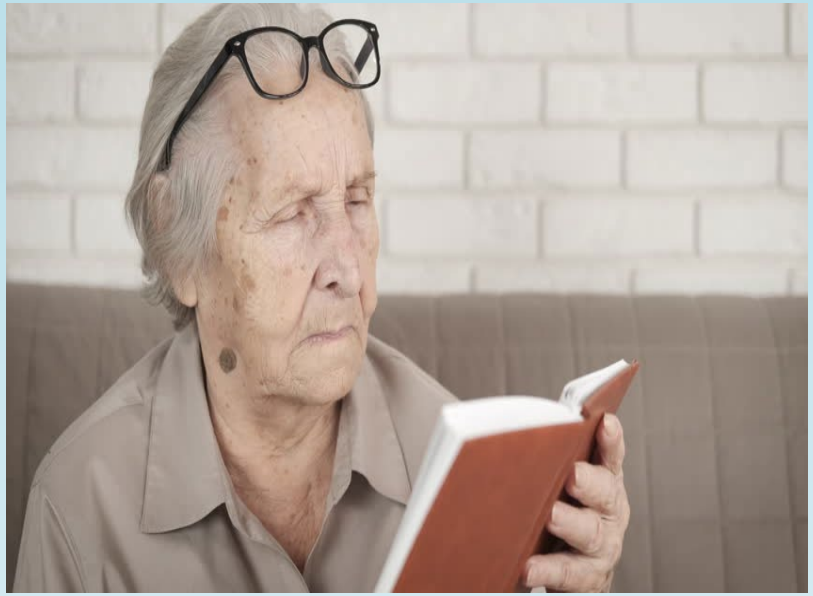
Sandra will report to her care coordinator acceptance of ARMHS worker by September.

# Case Study 1: Collaborative Care Plan

| 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 | I will report to my Care Coordinator 0 missed appointments by our next review. | CC to make referral for ARMHS worker and offer encouragement | 12/1/20 | 11/1/20-TC to member who reports she has only missed 1 app | 11/1- not achieved-ongoing. |

| 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 | I will report to my Care Coordinator acceptance of ARMHS worker by September . | CC to make referral for ARMHS worker and offer encouragement | 12/1/20 | 09/30/20200-TC to member who reports that she has seen her ARMHS worker twice now. | 9/30-Goal Met |

# Case Study 2: Clara



Clara is an 81 year old female with moderate Alzheimer's. Clara transitioned to living in a memory care facility about 6 months ago. Her family is present for her annual review. Clara states that all she wants is to “get out of here and go home”.  Her family who was taking care of her is unable to meet her needs any longer in a home setting (Clara had been wandering outside in the cold without shoes or a coat in the winter.) Her family wants Clara to settle in and accept this new setting as her home, and is frustrated that every time they visit Clara she asks for them to take her home.

Questions to the member to elicit goals:
Clara, what things to you enjoy doing? What do you enjoy about your home? What is your daily routine?

Questions to the family to elicit goals:
What did the member usually do at home, what is important to the member? What was the members routine at home? Do you have enough support in dealing with having a family member with Alzheimer’s?

# Case Study 2: Collaborative Care Plan

| 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 | Clara's family will report attendance to 1 support group meeting by the next review. | Care Coordinator to offer list of support group options. | 09/1/2020 | TC to Clara's family who state that they have reviewed the list of support groups and plan to attend soon. | 9/1/20-Goal not met, ongoing |
| | | | | | |
| ☐ Low<br>☐ Medium<br>☒ High | Assisted Living/Clara's family will report updating Clara's routine to her preferences by the next review | Care Coordinator to facilitate discussion between family and Assisted Living regarding member preferences. | 10/1/20 | 9/15/20- TC to family who state they were able to meet with Assisted Living staff and are working towards updating the members routine. | 9/15/20- Ongoing |

# Case Study 3: Tom

Tom is an 80 y/o male with the following chronic conditions: DM, Hypertension, and history of an MI. Tom is a new member to you and your are completing his very first HRA. Tom states that he gets to the doctor, but “not as much as he should” and that when asked about control of his Diabetes stated that yes, he checks his Blood Sugars most of the time, but that he doesn’t like all of  the finger pokes and shots. Tom also states that he doesn’t like his health care taking up so much of his time. Tom would rather be tinkering around in his garage, working on his car.

Possible Goals:

Tom will self-report checking Blood Sugars as recommended by his physician by the next review.

Tom will follow up with his Provider as recommended by target date.

Tom will self report discussing his testing concerns with his Provider by your next review.

# Case Study 3: Collaborative Care Plan

| 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 | I will report discussing my testing concerns with my provider by my next review. | Daughter to attend appointments for needed support. | 12/31/20 | 9/9/20- TC to member for Careplan review. Reports discussing his testing concerns with his doctor. | 9/9/20-Goal Met |
| | | | | | |
| ☐ Low<br>☒ Medium<br>☐ High | I will self-report checking my Blood Sugars as recommended by my Physician. | Care Coordiantor to encourage and assist with scheduling needed follow-up appointments | 12/1/20 | 9/9/20-TC to member who states they have been keeping track of Blood Sugars in a log book | 9/9/20- Goal Met |

# Case Study 4:Janice

Janice is a 67 year old female with the following diagnosis: Borderline Personality Disorder and COPD who lives in an independent senior apartment. Janice does receive care under a Psychiatrist and Psychologist. Janice is on a CADI Waiver and receives 3 hours/day PCA (ADL dependencies in bathing, dressing, grooming) and weekly homemaking. Janice has been having issues with staffing for her PCA/homemaking hours as she is verbally abusive to caregivers and others around her. Janice is now stating that she doesn't need anyone, and that she can manage on her own. You discuss the risks of declining services with the member and she agrees to contact you if she changes her mind.

I understand the risks of refusing services and will notify my Care Coordinator by target if my needs are not met.

I will self-report required follow up with my Psychiatrist/Psychologist by the next review.

I will  accept a list of PCA vendors from my Care Coordinator by target date.

# Case Study 4: Collaborative Care Plan

| | | | | | |
|---|---|---|---|---|---|
| ☐ Low<br>☐ Medium<br>☒ High | I understand the risks of refusing services and will notify my Care Coordinator by the target date if needs are not met. | Care Coordinator to offer encouragement.<br><br>Care Coordinator to provide list of Personal Care Attendant vendors. | 12/1/20 | TC from member requesting assistance with finding another agency stating, "I really need help now" | 11/15/20- 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<br>☒ Medium<br>☐ High | I will report keeping my follow up schedule with my Beahvioral Health team by review. | Care Coordinator to offer encouragement/scheduling assistance. | 12/31/20 | 11/1/20- TC to member who reports making it to all scheduled appointments the last few months. | 11/1/20- Goal Met |

# Practice: Making Goals SMART

**Current Goal**: I want to remain safe in my home at my highest level of independence, free of falls, injury and neglect with the following services to support me.

**SMART Goal Examples**:

(Member name, or I) will report no falls by next review.

(Member name, or I) will self report using my walker at all times by next review.

(Member Name , or I) will self-report completion of fall prevention safety program by next review.

(Member Name, or I) will self-report completion of an Occupational Therapy Home Safety Evaluation by target date.

# Practice: Making goals SMART

**Current Goal**: My Caregiver will verbalize adequate support in caregiver role.

**SMART Goal Examples**:

My Caregiver will self-report reading one book on caregiving by the next review.

My Caregiver will self-report attending monthly support group by December.

My Caregiver will reach out to Care Coordinator by next review if needing assistance finding respite resources.

# Practice: Making goals SMART

**Current Goal**: I will maintain stable mental health.

**SMART Goal Example**:

(Member Name, or I) will self-report establishing care with a new therapist by the next review.

(Member Name, or I) will self-report attending  monthly therapy appointments by next review.

**Current Goal**: I will have chronic pain managed as evidenced by member stating it is tolerable.

**SMART Goal Examples**:

(Member name, or I) will report a decrease pain by 1-2 points on a scale of 1-10 by target date.

# Tools and Further Resources:

| Source | Link |
|---|---|
| **MDH:Worksheet** | https://www.health.state.mn.us/communities/practice/resources/training/docs/1601-objectives/handout_goals-objectives.pdf |
| **NCQA: Goals to Care Article** | https://www.ncqa.org/wp-content/uploads/2018/07/20180531_Report_Goals_to_Care_Spotlight_.pdf |
| **Medica Care Coordination Website: SMART Goal Example Guide** | https://www.medica.com/-/media/documents/exclude-from-search/care-coordination/training-manuals/smart-goal-example-guide.pdf?la=en&hash=ED6693C742DEE42C2D0CAC1E4109AEFC |
| **Motivational Interviewing** | https://alliedhealth.ceconnection.com/files/MotivationalInterviewingBuildingRapportWithClients-1352212913026.pdf |
| **Resources for Integrated Care: Using Person Centered Language** | https://www.resourcesforintegratedcare.com/sites/default/files/Using_Person_Centered_Language_Tip_Sheet.pdf<br><br>https://www.resourcesforintegratedcare.com/sites/default/files/Using_Person_Centered_Language_Graphic.pdf |

# Reminders:

- Session 3 will be up on the Care Coordination Website within 1 week
- Please turn in your attendance sheets by Aug 31st
- CEU's will be sent out along with Session 3 Questions and Answer's
- All 3 Session Q and A will be compiled and uploaded to the Care Coordination Website

# 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