Senior Care Options
GSSC
Plan of Care Training

September 2019

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Agenda

1. View video: The Patient Centered Care Plan
https://micmrc.org/sites/default/files/courseware/care-planning-3/index.html

2. Care Planning Using Current Systems

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Purpose

- Provide tools and training to support member-centric plans of care for Community Well members
- Provide direction as how to best document Plan of Care actions within current version of Case Trakker
- Review Plan of Care Interventions assigned to GSSCs for AD/CMI and NHC members

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GSSC Model of Care Role Changes

- Per CMS Corrective Action Plan:
  - Tufts Health Plan SCO must discontinue the GSSCs performing one of the level 4 assessments by December 31,2019
  - Model of Care changes are being rolled out beginning October 1,2019 with follow-up and re-contracting by December 31, 2019
- The changes will be rolled out in phases based on the ASAP and Tufts Health Plan's SCO readiness
  - Phase 1: October 1st
  - Phase 2: November 1st
  - Phase 3: December 1st
- Discontinue Level 4 (NHC) assessments
  - Take specific Level 4 Care Plan Interventions
  - Assume responsibility for Level 1 (Community Well) Member Care Management

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Plan of Care:
Community Well Members

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Assessment Priorities for Community Well Members

- Preventive Health
- Vaccinations
- I-ADL Needs
- Advanced Directive on File
- Loneliness
- Physical Activity Plan

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Steps in Care Planning Process

- Conduct comprehensive assessment
- Develop a problem list (based on assessment findings)
- Use the problem list as the starting point to develop the Plan of Care
- Prioritize the Problems
- Set Goals (use **SMART** goals as a tool)
- Establish timeline for follow-up
- Obtain agreement with member on short term goals and which actions are assigned to the member
    - Problems can be completed in 6-12 months
- Create the ICP Document and Cover Letter and place in ready to send
- Task SCO Clinical Consultant (SCC) to review chart after each Community Well Assessment is completed
    - SCC will task RN Supervisor to review POC annually
- Update Plan of Care with subsequent assessments as needed

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Goal Setting

- Goals should always be **SMART**: Specific, Measureable, Attainable, Relevant and Timely
- The long term goal should not be longer than one year
- A short term goal should be focused on addressing immediate barriers and completed by next assessment period (6 months)
- Do *not* use the goal prioritization feature
- Do *not* push out goal due dates
  - If goal is not met, indicate goal outcome as "Not Met Clinical" (unless member truly refused to participate)
  - Revisit interventions and create if new goal if needed

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SMART GOALS

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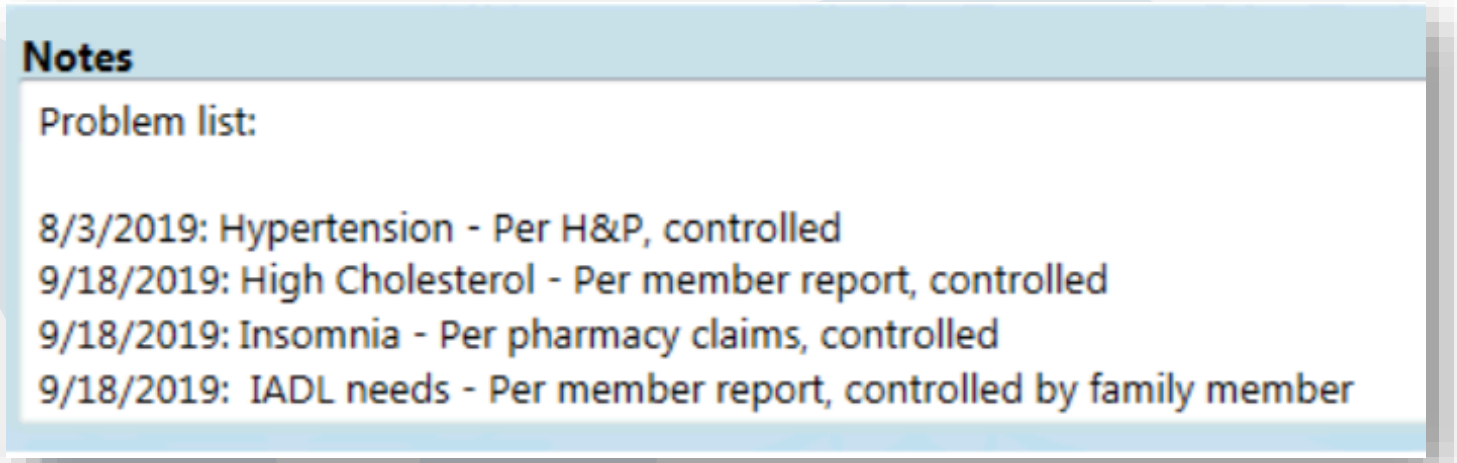
Creating and Maintaining a Problem List

- The problem list (problems or conditions impacting member's well being)
- The GSSC should review and update the problem list as needed, using the following components:
  - Assessment results
  - Pharmacy claims
  - The History and Physical (H&P) from the PCP
  - Any other information about medical changes
- GSSC should task the Care Coordinator at least two weeks prior to annual assessment to obtain History and Physical
- Through a review of this pharmacy and medical information to identify any change in condition
- This can trigger the need for reassessment for potential re-leveling by a Nurse
- The GSSC should consult with SCO Clinical Consultant if they have questions about pharmacy claims, diagnoses or utilization

Creating and Maintaining a Problem List (cont.)

Documenting the Problem List:

- Date of Problem identification (also date if resolved)
- The Problem list will be documented in the **notes section** of the POC



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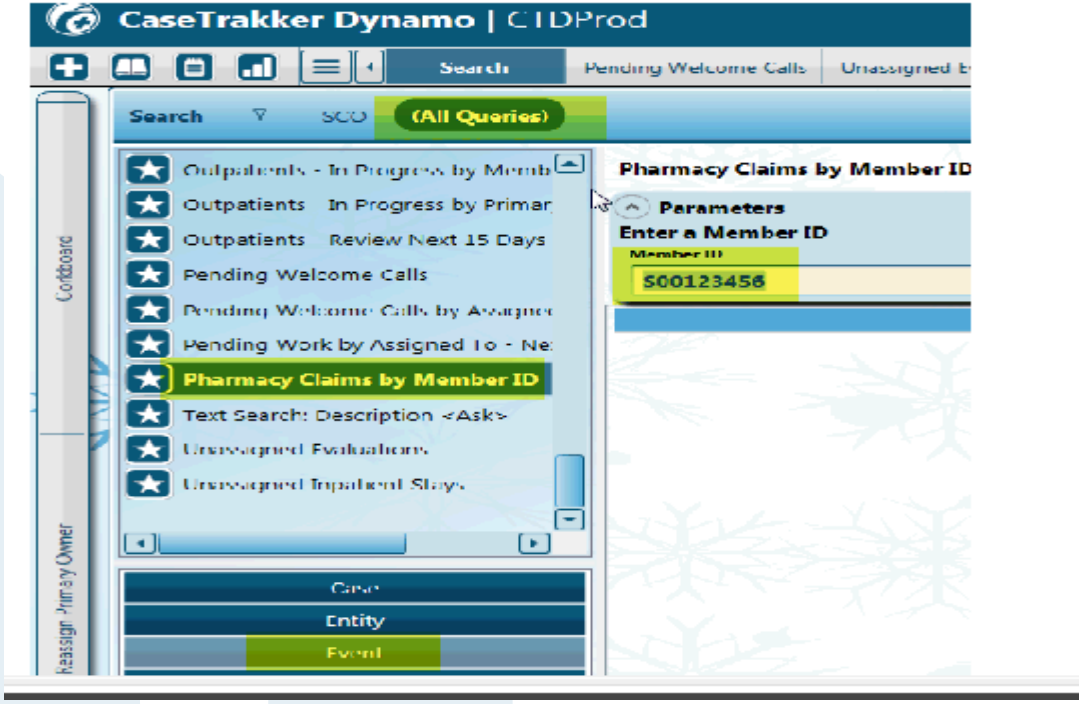
How to Look Up Pharmacy Claims

- All Queries > Event > Pharmacy Claims by Member ID > type in THP S number. You can use the filter to sort.

- This will give you a list of most recent medications the member picked up at the pharmacy.



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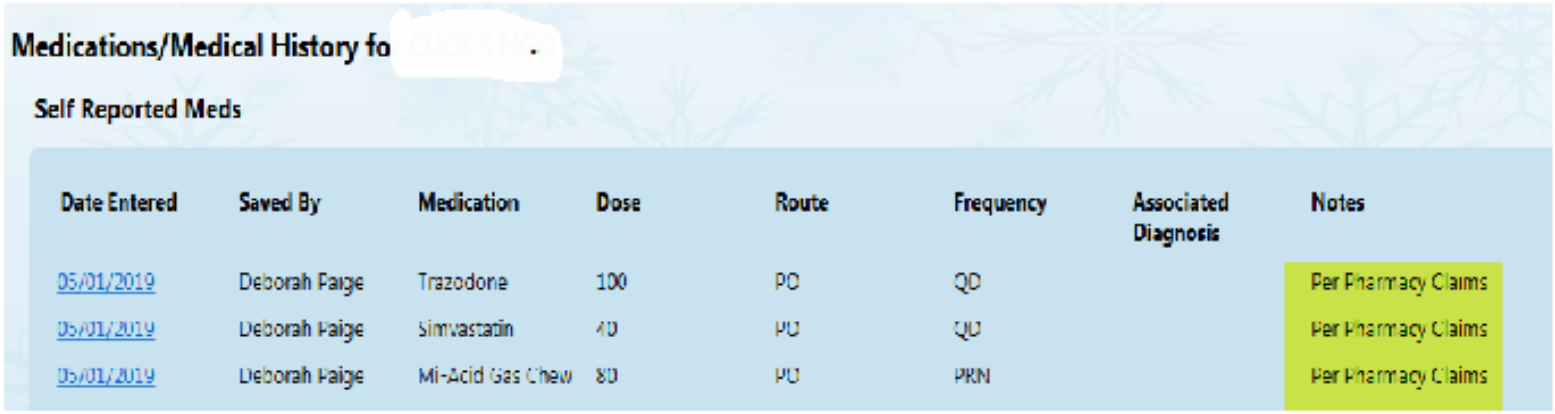
Medication/Diagnosis Tab

- Ensure all medications on the Health and Physical, in Pharmacy Claims and in the home are documented
- In the notes section of each medication identify where you obtained the info ex) pharmacy claims, H&P, member reported, in home, etc.
- If there are any major discrepancies or new medications that may require a level change task the SCO Clinical Consultant



Medications/Medical History fo

Self Reported Meds

Date Entered	Saved By	Medication	Dose	Route	Frequency	Associated Diagnosis	Notes
05/01/2019	Deborah Paige	Trazodone	100	PO	QD		Per Pharmacy Claims
05/01/2019	Deborah Paige	Simvastatin	40	PO	QD		Per Pharmacy Claims
05/01/2019	Deborah Paige	Mi-Acid Gas Chew	80	PO	PRN		Per Pharmacy Claims

Putting the Plan of Care Together

- Keep it simple and focused with no more than 1-3 problems prioritized
- Whenever possible, use the Problem Goals and Interventions (PGI) spreadsheet to manually insert content into the Plan of Care
- Assign the interventions to the appropriate Care Team member including member as needed
- Use the Teach Back Method to confirm member's understanding

Teach Back Method

The "Teach Back" is a technique used to replace the more common practice of asking the member "*Do you understand*"?

Example:

Once information is given to the member, confirm their understanding…

"*I want to make sure I explained everything clearly to you. Can you explain it back in your own words"?*

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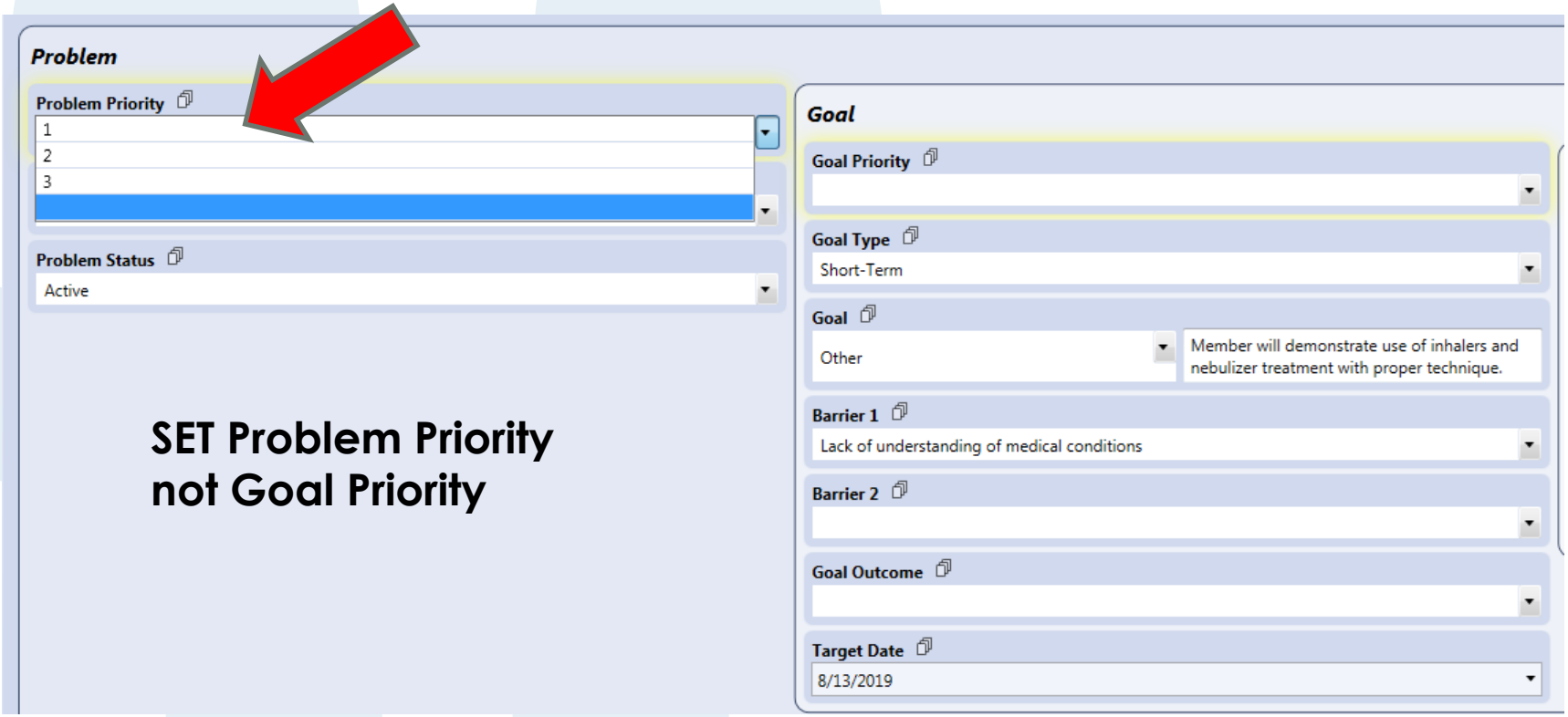
Problem Prioritization



SET Problem Priority not Goal Priority

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Identifying and Assigning Interventions

- Designate Interventions to be completed by Member, GSSC or a Care Team member
  - Task self or appropriate care team member with any short term interventions
  - Once intervention is complete, assigned staff member to change intervention status to “Complete”
  - Interventions related to short term goals should be completed by the next assessment
    - *Documentation should be provided for any interventions not completed*
  - Task self a reminder to follow up on any actions specifically assigned to member

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Some Examples of Care Plan Interventions

Problem	Goal	Intervention	Routine Screening/Immunization recommendations for age 65 and over
Lack of Screenings	Short Term Goal: Member will understand importance of needed screening and update Mammogram before target date.	Educate member on importance of age/gender related screenings. Advise member to contact PCP to schedule a Mammogram.	Recommendation: Obtained Annually
Lack of Screenings (Eye exam)	Short Term Goal: Member will understand importance of needed screening and update Eye exam before target date.	Educate member on importance of obtaining an annual eye exam. Advise member to schedule exam with their provider.	Recommendation: (Diabetics should have a dilated eye exam and glaucoma screening Annually. If no diagnosis, exam every 2 yrs).
Lack of Screenings (Hearing exam)	Short Term Goal: Member will understand importance of needed screening and update Hearing exam before target date.	Educate member on importance of obtaining a hearing exam. Advise member to schedule exam with their provider.	Recommendation: Hearing exam- every 2 yrs.
Lack of Immunizations (Influenza Vaccine)	Short Term Goal: Member will understand importance of needed immunization and update Influenza Vaccine by target date.	Educate member on risks verses benefits of obtaining the flu shot. Advise member to go to local pharmacy to obtain or PCP office.	Influenza Vaccine Annually (unless allergic to eggs).

Care Team Tab

For Community Well Members: include the Member, Caregiver, the PCP, the GSSC, and the RN Supervisor at minimum

Also include other routinely involved providers who are consulted with if applicable

Care Team for Mary Poppins

Date Entered	Involvement	First Name	Last Name	Effective	Term	Comments
05/24/2019	Member	Ellen	Henson	3/13/2019 12:00:00 AM	1/1/2050 12:00:00 AM	
05/24/2019	GSSC	Kerri	Lyford	3/13/2019 12:00:00 AM	1/1/2050 12:00:00 AM	
05/24/2019	PCP	Michael	Smith	8/21/2019 12:00:00 AM	8/18/2028 12:00:00 AM	
05/24/2019	Family Member	Mary	pires	3/13/2019 12:00:00 AM	1/1/2050 12:00:00 AM	Caregiver
05/24/2019	CM Support Staff	Deborah	Paige	8/28/2019 12:00:00 AM	8/14/2026 12:00:00 AM	RN Supervisor

Care Plan Review and Approval

- The Plan of Care, which includes PGIs and the service plan should be reviewed with the member during home visits

- After your visit:
  - GSSC to summarize the assessment visit in the clinical note template
  - Under Plan of Care/Areas of Concerns Section
  - GSSC to put "*Verbal approval from member on Plan of Care and Service Plan*"

- A revised ICP needs to be issued by the GSSC at minimum every 365 days from the initial or last annual ICP. Tufts Health Plan SCO Admins will then mail the IPC and Member Summary to member and PCP

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Updating the Plan of Care

As of **October 1:** Implementation of new care planning approach will begin for all initial and all annual care plan updates and ICP mailings

- Changes should be reflected on the Plan of Care in real time
- Plan of Care should be reviewed upon each interaction with the member
- A new IPC should be issued with any significant changes in the Plan of Care

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Unable to Reach and Refusals

- Must document in Case Trakker at minimum 3 call attempts and issue a letter for all unable to reach members
  - Notification of a member believed to be Out Of Area (OOA) should be emailed to Tufts Health Plan's Enrollment Department when identified. Enrollment will conduct a 6 month process of monitoring member status.
  - When member returns to the area GSSC is to email Tufts Health Plan Enrollment Department asking to stop Out of Area Process

- The Unable to Reach and Refusal processes have been updated to reflect expectations around alternative means of trying to reach the member

- Unable to Reach and Refusal members are required to have a Plan of Care created and an initial and annual IPC issued

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Plan of Care:
GSSC Role for AD/CMI and NHC members

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Plan of Care Interventions Assigned by the RNCM to the GSSC

- RNCM will add a **goal** to the Plan of Care with **interventions** that will be assigned to the GSSC
- The RNCM will task the GSSC from the **green** check mark within the Plan of Care; the task will include a brief explanation of the member needs and any other pertinent information
- The RNCM and GSSC should collaborate on the member's Plan of Care

Documentation:

- GSSC will document the progress made towards the goal in the activity log using the provided Plan of Care Note Template
- RNCM will update the Plan of Care, and if the goal(s) have been met and there is no further assistance needed from the GSSC, the goal will be closed by the RN
- GSSC will be invited to IDT meeting for difficult to manage members and high touch members as needed

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Examples of Plan of Care Interventions

GSSCs will be asked to perform Plan of Care interventions for AD/CMI and NHC members

- Provide education to members regarding chronic disease self-management
  - Is COPD or CHF Action Plan in a visible location?
  - Are members with Heart Failure monitoring their weight and fluid intake?
  - Do members have healthy food in the refrigerator?
- Encourages healthy behaviors and support members in developing healthier habits
- Assist members in finding PCP's, specialists and access to other needed health care services
- Assist members with scheduling and attending appointments if needed
- Promote health screenings and immunizations as needed
- Assist with completion of advanced Directives: HCP/MOLST forms
- Assistance illiterate members with correspondence and provide education on SCO Benefits

**** All GSSC Responsibilities are built into the Plan of Care***

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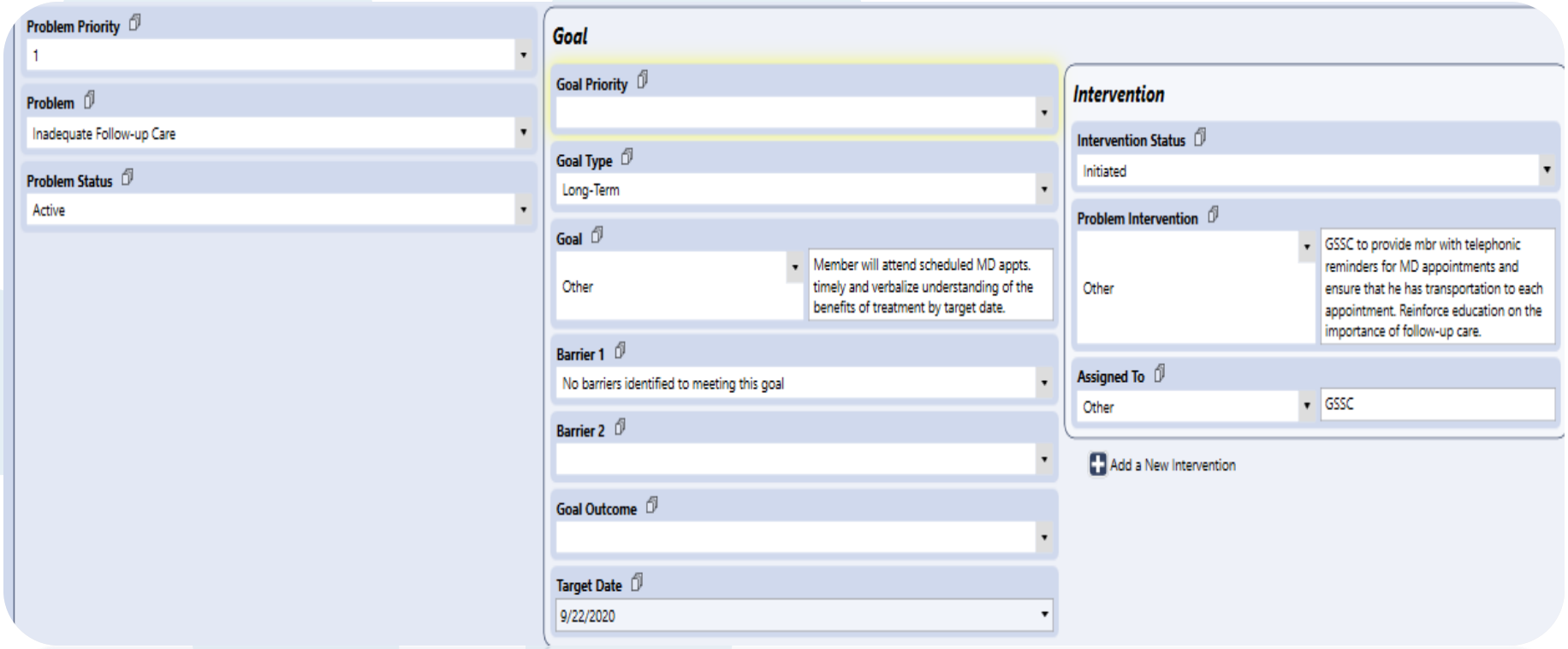
Example of an Intervention assigned to GSSC



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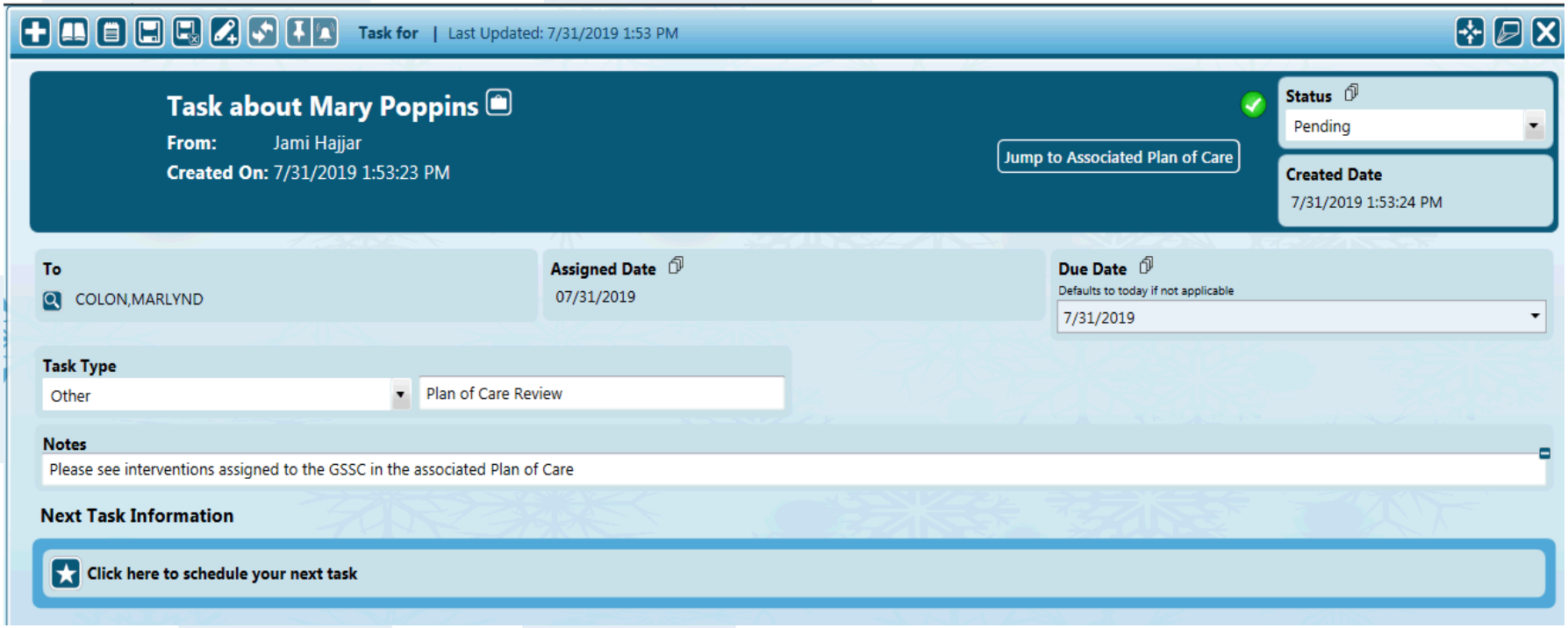
Plan of Care Example Task



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GSSC Plan of Care Note Template

Date/Time of visit:

Observations: (ex. pleasant calm mood. Appearance: well-groomed/unkempt cooperative/uncooperative, etc.). Living conditions and support network. Source of information (ex. Member vs family member).

Member-centered goals addressed:

Goal 1:

Intervention: (i.e. Health promotion/education provided)

Member response:

Plan (Please include responsible person, date/time of next planned visit):

Goal 2:

Intervention:

Member response:

Plan (Please include responsible person, date/time of next planned visit):

***Add additional goals as needed**

<u>Key Points for documentation:</u>

- Review plan of care intervention assigned with the member (member's goals and the intervention assigned to the GSSC interventions)
- Assess and document any member safety concerns or unexpected findings/behavior at each visit
- Document evidence of coordination/ communication with the RNCM post the member visit

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GSSC Plan of Care Note Example

Date/Time of visit: 9/12/19

Observations: Member alert and oriented, calm, well-groomed, cooperative, apartment well kept. Source of information: Member

Member-centered goals addressed:

Goal 1: Member will attend MD appts. timely and obtain all prescribed medications from pharmacy.

Health promotion/education provided: Member has missed several appointments in the past. GSSC educated member to the importance of following doctors' orders, recommendations and encouraged to attend appts. Offered to help translate follow-up instructions and set-up a companion or PCA to escort if needed.

Member response: Member happy with this outcome and states she feels better about going to appt. with assistance.

Plan (Please include responsible person, date/time of next planned visit): GSSC to make reminder and follow-up calls to the member to review post appt. instructions and ensure member has obtained medications from pharmacy if ordered. Set- up an escort to attend next appt. with PCP on10/8/2019. RNCM notified of members progress towards reaching goals.

Goal 2: Member to weigh self-daily, maintain weight log and have a good understanding of appropriate low salt food choices by target date.

Health promotion/education provided: Education provided to the member to weigh self-daily in am prior to eating breakfast and to call PCP if weight is up 2-3 lbs. in one day. Assisted member to create a log and advised to keep near scale for daily documentation. Also educated to follow a low sodium diet, to avoid high salt foods; canned goods, lunch meats and to season foods with no salt alternatives (Mrs. Dash). Reviewed canned goods currently in home and educated to read food labels, attempt to eat less processed foods.

Member response: Member has placed a scale in her kitchen as a reminder to weigh self-daily and agreed to keep a daily log. Member also agreed to not use shaker salt on foods and will have her daughter purchase Mrs. Dash to try instead of salt. Member reports her daughter will make a few prepared dishes that can be reheated.

Plan (Please include responsible person, date/time of next planned visit): GSSC to contact member weekly to review compliance of weight log and diet. Plan to reinforce teaching member to read food labels. RNCM notified of members progress towards reaching goals.

Plan of Care Documentation Process

- GSSC to document progress or updates using the Plan of Care Note Template
- GSSC to task the RNCM off of the note template
  - Other > Plan of Care Review
  - RNCM will update the Plan of Care as needed
- Expectation is that ASAP will have a scanner to attach any key member documents in Case Trakker

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Any Questions?

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