



TRANSCRIPT

Care Planning Plan Presentation by:

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Well I am really delighted to be here and share the Hopkins Elder Plus Experience with Care Planning. I'm not presenting this as a model to be replicated necessarily; it's on programs experience and one programs evolution that I wanted to share with you. It's very much a work in progress.

Before I give you a little background on Hopkins Elder Plus and move into the presentation, I wanted to mention that the slides are in your book. They're missing the first four or five slides. So if you start to follow along and think that you missed something, it's slides that are missing.

You also have a copy of the poster that somebody told me today they were calling the placemat. So you should all have a placemat that's a copy of the larger poster that's outside.

I'd like to mention another thing, and that's to acknowledge the clinical director of Hopkins Elder Plus, Janet Bonsack who really was the champion and the driver for this care plan evolution the past year. And she presented this same information at the national PACE association in San Francisco last month. And that's Janet Bonsack, if you would get up one minute please. So Janet and I have an agreement, I give the presentation, she answers the questions. So I hope you're ready for that Janet.

So just as a background, a lot of you know this but Hopkins Elder Plus opened in 1996, we're in Baltimore Maryland, were one of the original 15 PACE demonstrations. We're sponsored by a large health system, the John's Hopkins Health System, we're located on a large medical campus, and we have an enrollment cap of 150, that's capped by the state. We have one interdisciplinary team and we do not have an electronic medical record at this time, I'm anticipating that question.

So, let's, we saw this slide actually and a national PACE Association Spring Policy Forum, someone from CMS reported this information, 46 PACE sites in 2009, the most common deficiency was care planning. And the percent deficiency in PACE overall was 63% and in rural PACE 79%. So I think that kind of points out that this is an important topic that we're all working on. So, just to tell you a little bit about what we had before we initiated our Performance Improvement Initiative with Care Plans we had a multidisciplinary care plan.

Some of this may sound familiar to you, it was an all paper process, it was done at intake, an assessment meeting. That's where we reviewed each disciplines care plans, it was dominated by nursing. Nursing really was very comfortable with care plans and our other team members weren't so comfortable so it was pretty much dominated by nursing which was something we knew we wanted to change. The other team members especially had a lot of trouble with

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measurable goals and separating what's an intervention and what's a goal and what's an outcome and we're still clarifying that all the time. I see some of you out there shaking your head, that's very reassuring. Trouble with team goals, we really didn't have any good robust team goals. And we called; we really decided that the document was a stale document. The care plan just kind of sat in the medical record and was something we had to pick up when there was a significant change or we had to pick up for that semi-annual assessment but it just wasn't as robust as we wanted it to be. So in the Summer of 2009 we decided to look at our care plan and we got the interdisciplinary team brainstorming what is it that we want. We reviewed the PACE regulations and we searched for best practices. We actually talked to a couple of other PACE sites, we looked at a couple of vendors who had electronic care plans to see if that would work for us and then we decided to develop our own care plan.

So the interdisciplinary team wish list, and our criteria for the new process we wanted it to be somewhat electronic, accessible and user friendly. We wanted to format it to ensure input from all disciplines, structured for efficiency, structured for consistency, easily personalized. And we wanted to capture the participant's strengths, we hadn't done a good job of that in our previous, so we wanted to build that into the new system. And we wanted whatever we did to culminate with team goals. We wanted it to be a living document and we wanted it to be easily updated in the morning meeting. So those were our goals.

So, in the fall I introduced Janet Bonsack, our clinical director and she collaborated with our information services, our technical person at the program and we developed a home grown access database and it was a lot of back and forth meshing of clinical needs and our wish lists with the technical capabilities of an access database. We got continuous team input. We renamed that INA. How many of you still have an INA, not many? We renamed that interdisciplinary care plan. It just sounded more like what we were doing and we would do and redo and do and redo. So it was a lot of work that went into it. In the winter of 2010, we decided to generate a lot of team enthusiasm. We reviewed this product that we developed that was still very much in the development stage in small groups with different disciplines so each discipline could clearly say what their concerns were; maybe add to the wish list for that program and we began to develop what we call e-libraries and that is actually in the access database but it's hidden and it's common problems or needs that we have given a number to. If you pick fall risk and that's number one, we were developing goal statements or outcome statements for falls. So there is a list of goals or outcomes that we could go in and select and see what is most appropriate for this participant. At the same time, we go in to number one in the interventions e-care planning library and come up with our interventions that could be selected. We weren't sophisticated enough with our home grown access database to do drop down boxes and things like that. That's kind of where the tension came in; where maybe we would have liked nice drop down boxes. We didn't quite get that, but we're very happy with the e-care planning library.

Of course, we incorporated feedback and did reprogramming. In February 2010, we decided on a go live date. Again, we were generating a lot of enthusiasm, I think because the team had so much input and had seen the development all along, they truly were enthusiastic about it. Each discipline in this access database has their own tab or section and in each one, there is a place for a need or problem; maybe one, maybe two, maybe three; measurable goals. Again, they

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have the help of the e-planning library. They don't have to sit there and think how am I going to word this; and the interventions. Some disciplines in their section have some specific indicators that they're also recording on. For instance, in the rehab section they're reporting on a Byrd balance score so that's always part of the assessment. In the nursing section, there is always a Braeden score for pressure ulcer risk. It makes it very consistent. We make sure that we're capturing all of these assessments in a systematic way. The way this happens is the individual disciplines and departments do their assessment and then we come together for this ICP meeting and this is projected on a screen. The care plan is projected on a screen. Everybody is focused on the care plan. In our previous process, that was paper and multidisciplinary. It seemed like everybody was sitting there looking down at a paper at the table. I don't know if anybody can relate to that. One medical record paper looking down. This way, in the team, we're all focused on the screen and we're all focused on this interdisciplinary care plan. Each discipline gives their assessment. There is conversation, as I'm sure there is in your program, back and forth. Disciplines may adjust some goals or adjust some interventions based on what they've heard and then we move on to establish team goals.

What we did with team goals and I don't have those listed here, but they're actually listed on the placemat, but you might not be able to see them. What we did with team goals is we identified about seven categories that we thought were broad categories for team goals. It just gives a team a starting place. It doesn't mean that they have to be confined to that. It just means that it's a starting place. The team goals are in categories like adjustment, pain, comfort, and end of life care. There are some broad categories and again, we're still refining these. The team can say yes, what we're really working on here is adjustment – adjustment of the participant, adjustment of the caregiver to this new care setting. Then what we can also go in to the library for team goals and pick that team goal, see some good outcome or goal statements, modify it to fit this situation and also choose intervention similarly. It just makes the process more efficient. For the periodic assessments, of course we have month one where we're establishing the care plan and then in month six for the periodic semi-annual assessment, we evaluate the care plan that was developed, we add adjust or change, we said that our goal outcome was met, partially met or not met, and then we make a statement about why we said that and whether we're going to continue the care plan, modify the care plan, modify the interventions, etc. So there is a real evaluation of what we decided we were going to do in month one.

What happens between month one and month six when obviously we're going to have changes? We developed another part of the access database we can go into called the Care Plan Addendum. This is a page that we can pull up in morning meetings. When we're in morning meetings, somebody can go to the computer and pull up the Care Plan Addendum for that participant on the screen. Then we can reference problems or needs in the care plan and say what's going on and how we are going to update it. That is one piece of paper. Obviously, we would like to have everything on one piece of paper, but that was another limitation of our access database. That seems to be working very well. We have all of the updates on one report with cumulative entries.

What are our challenges and opportunities? As I said, it is still a work in progress. There are some ongoing technical glitches. An access database, if you have any experience with that, is not necessarily suited to multiple users. You really have to convert it to a Sequel platform,

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which we were actually able to do in our system. You want to convert it to a more secure platform to protect it. Developing team goals is still challenging. We still get to that part in the meeting where we say, “Okay, what is the team goal?” I think Janet would say that we’re definitely making progress there. The library has helped a lot because you have some ideas there. Getting team involvement in library building – we want this library to be a growing library, a living document that we’re always changing.

When we have a new problem; like we recently experienced problems with bed bugs. Anybody have any bed bug problems? As we were developing our policy and finding out what we should be doing about that, we said let’s get a bed bug care plan in there. Let’s get that into our care plan e-library right away with our goals and our interventions. We are getting better about remembering to do that. We have our performance improvement initiative for this year is pain management. What we are requiring of everything that we learn with pain management is that we have entries for the e-care plan so that we are making sure that we’re building that library. Then of course is establishing team members’ competency with the product. We do have a test that they have to pass; each team member, that asks questions about the process, the regulations, etc. They have to problem need goals and interventions with measurable timeframes, etc. so they have to demonstrate that they can do that. Then there is an observation of them being prepare for the ICP and how they do. We have a pretty robust competency . Documentation of participant and family input and review – that is always a challenge for us. Our social workers send out a letter twice a year saying we have this ICP and you are welcome to come. Sometimes we have family members on the telephone, but we prefer to have them in person and that is challenging. Then of course is getting everybody in the habit of updating the addendum page; making sure that we’re doing that and making sure that we are paying attention to the significant change process.

That is the presentation. I hope that you maybe heard some things there maybe that you are struggling with and, if anything, maybe it’s an affirmation of this is a challenging topic but stick with it.