CREATING SMART PERSON-CENTERED GOALS

Blue Plus Partner Relations Team

2022

LEARNING OBJECTIVES

- Understand the SMART acronym and how to apply it in your goal planning
- Create a SMART person-centered goal
- Learn ways to transform needs into SMART goals
- Recognize Care Plan requirements and expand your knowledge of documenting progress and outcomes on care plans

POLICY DRIVES PERSON CENTERED APPROACHES

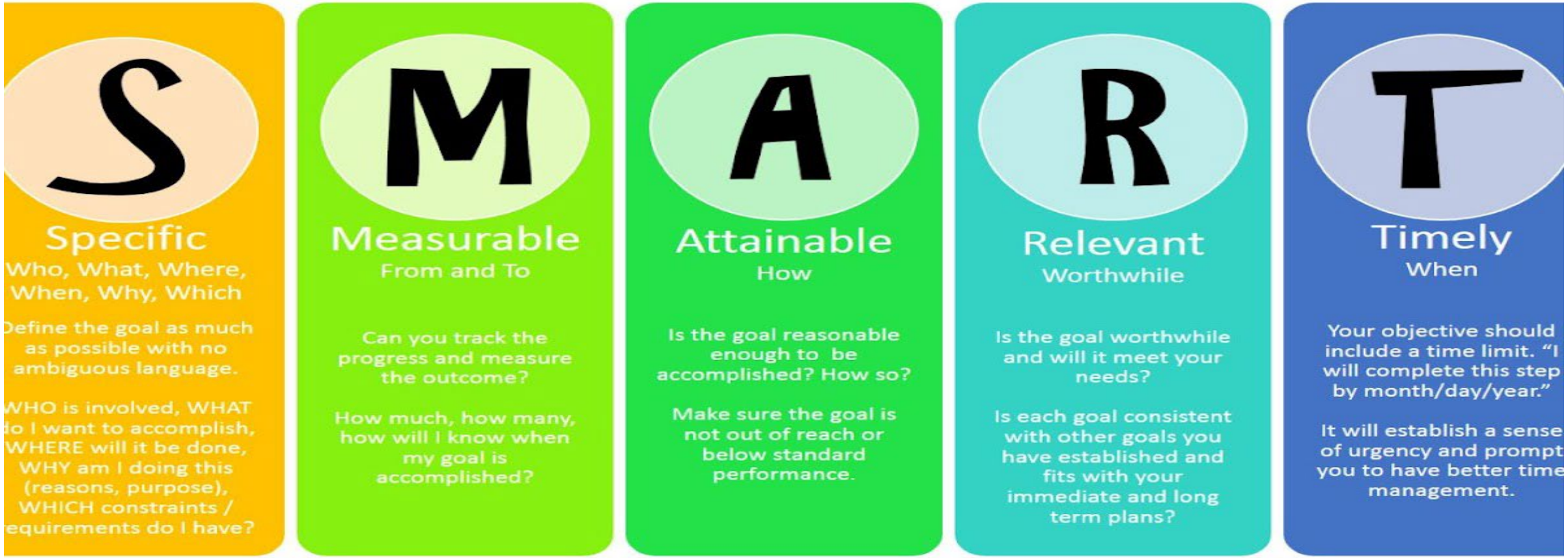
CMS and DHS

- MN Statute 245D
- CMS Home & Community Based Service Rules
- Americans with Disabilities Act (ADA) and the Olmstead decision

BARRIERS TO CREATING GOALS

- Goals are not realistic or attainable
- Members do not think in terms of goals
- Lack of knowledge on SMART goals

WHAT ARE SMART GOALS?



WRITING A SMART GOAL

SPECIFIC:

State the goal clearly; use a person-centered statement

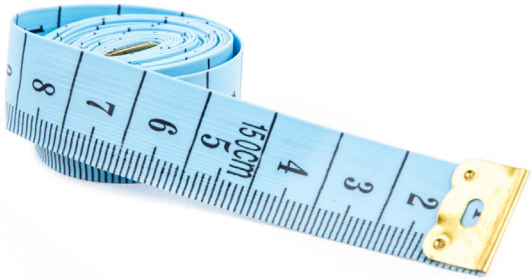
NOT SPECIFIC

Care Coordinators can use motivational interviewing practices to help members express their goals. Use Open-ended questions

WRITING A SMART GOAL

MEASUREABLE:

WHAT	How Measured
Lose 10 lbs	Weekly weight check; self-report
Smoke less than 10 cigarettes per day	Self-Report
A1C <6.5	Clinic records; self-report



MEASURABLE GOAL:

Rank by Priority	My Goals	Support(s) Needed	Target Date
☐ Low ☐ Medium ☒ High	Sam states he would like to lose 10 lbs by 12-31-22	Sam will monitor his weight weekly and record Sam will walk 30 min/day Sam will make make smart food choices and monitor his portions Sam will eat more fruits and vegetables Sam will limit his snacking to 1 x/day. Sam will consider Silver Sneakers membership	12-31-22

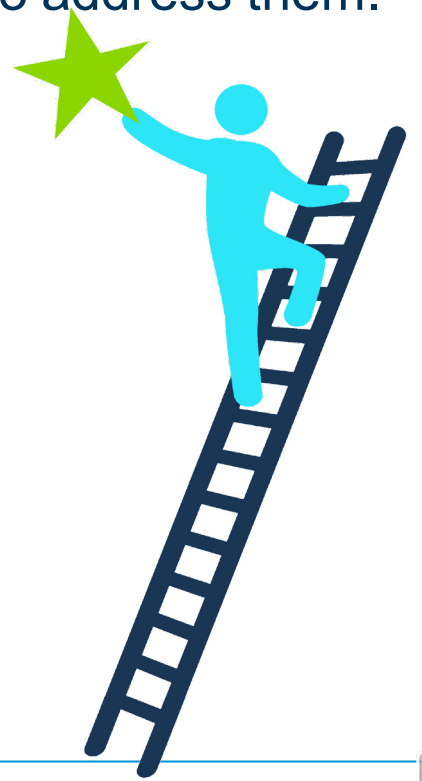
WRITING A SMART GOAL:

ATTAINABLE:

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

NOT Attainable: I want to be smoke free

Attainable: 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 ☐ Medium ☒ High	Sam states he would like to smoke no more than 10 cigarettes daily	Care Coordinator will provide education on health plan's smoking cessation programs. Sam agrees to schedule appt with his PCP to discuss treatment options for smoking cessation Sam will take his medications as prescribed Sam will walk 30 min/day to feel healthier	12-31-22

ACTION STEPS

WRITING A SMART GOAL:

RELEVANT:

Make sure the goal reveals what's most important to the individual. CC can use motivational interviewing skills to help identify needs from the assessment to goals

- Is this goal relevant to member's current situation?
- Why is this goal important to your member?
- How will this goal benefit the member?

WRITING A SMART GOAL:

TIMELY:

Define the period in which the goal will be obtained and agree when to check and monitor progress.

- Is this a long- or short-term goal?
- Prioritize by importance
- Are there any barriers that could prevent the goal from being completed
- Schedule the time to follow up and review progress

SUPPORTS AND INTERVENTIONS

Who/What

Document any interventions that are related to achieving the goal

May document multiple interventions and supports for one goal

Who will help the member attain the goal (Formal/Informal supports, Ex. HHA, daughter)

Examples:

- Sam will always wear his PERs (personal emergency response system) pendant daily.
- Care Coordinator will provide education and resources on smoking cessation
- Sam will walk 30 min/day
- Sam's HHC nurse will assist weekly with refilling his med boxes and monitoring adherence
- Sam's daughter will assist with transporting to scheduled medical appts
- Sam will call and schedule a MD appt to discuss smoking cessation options.

TIPS AND TRICKS FOR CREATING GOALS

Person Centered

- Use member's name or I statement. Refrain from using "member"
  - Ex. Sam would like to, wants to, etc. (refrain from using "will or "should"
- Build trust
- Respect the individual's preferences
- Ask open ended questions, Reflect, and Summarize
- Listen for cues i.e., excitement about a topic, current struggles, etc.

TIPS & TRICKS FOR CREATING GOALS

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Gather information from assessment to identify a goal

Identify barriers
Avoid acronyms and clinical language (PCP, PCC, HHA, CHF, HHA, etc.)

Encourage and Inspire-learn what motivates them
Promote self-advocacy and self-realization

Use Motivational interviewing
Being able to craft the answer to express what the member wants to meet goal expectations

SMART VS. NOT SMART PERSON-CENTERED GOALS

Not SMART 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 10 lbs over the next 12 months
Member will be compliant with high blood pressure meds daily	Sam agreed to take his Blood pressure daily and record for the next 12 months
Member will be free from falls	Sam would like to be free from falls for the next 12 months

TOOL

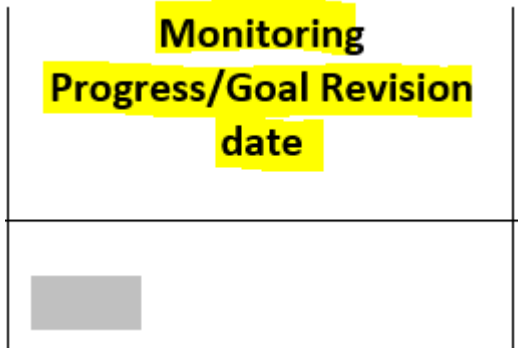
Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					
☐ Low ☐ Medium ☐ High					

List month and year as target date

Document the date (month/year) the goal was achieved or if not achieved, and the date it was reviewed

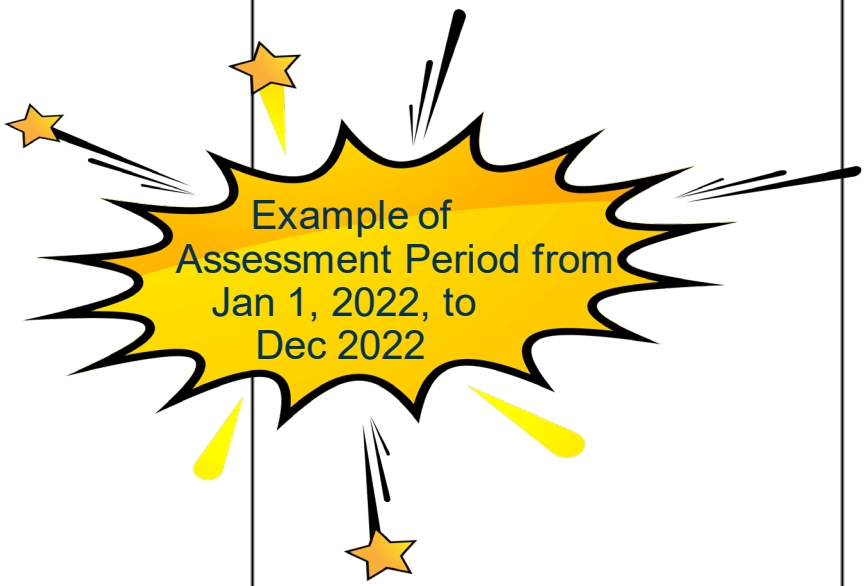
DOCUMENTING PROGRESS OF THE GOALS

- The Care Coordinator should have a discussion with the member about each goal and the member's progress towards meeting the goal
- Discussion should include determining if the goal was met or not and an evaluation of whether the goal will be discontinued, modified, or carried forward to new care plan
- Document progress of goals on the care plan at the mid year visit and throughout the year as needed
- Include the month/year of the review and a brief progress note in the ***monitoring progress/goal revision date column***



SAMPLE PROGRESS NOTES

Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date
☐ Low ☐ Medium ☒ High	Jane wants to see her dentist by the end of Dec. 2022	CC will provide Jane with the number to Delta Dental for a list of dentists in her area. Jane's dau/Jamie will assist with transportation to appt. Jane will call and schedule an appt CC will assist Jane with coordination of appt if needed	12-31-22	3-12-22 CC spoke with Jane on progress of this goal. Jane called Delta Dental and has a list of dentists in her area. Jane will call and schedule an appt and dau will assist with transportation needs. 6-24-22 CC met with Jane today for 6 mo. visit. Jane reports completing her annual dental exam. Jane has another routine appt in Dec for exam and cleaning.



Progress Notes

GOAL OUTCOME DOCUMENTATION

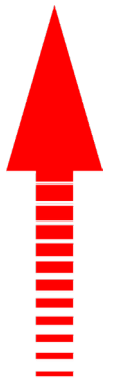
Outcomes are documented in this column

Document the outcome of each goal as follows:

1. For each goal, document the month and year
2. Note the following:
   **Goal achieved or not achieved
   **Document whether goal will be discontinued, modified, or carried forward.
3. You may also document a progress note in this column

SAMPLE OF OUTCOME DOCUMENTATION

Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☐ Medium ☒ High	Jane wants to be free from falls over the next year	CC will arrange for Physical Therapy safety assessment Customized Living Staff will assist with transfers in and out of chairs and bed for safety Jane will wear her PERs at all times Jane will use her walker as needed	12-31-22	2/2022 PT evaluation completed and recommendations given to customized living staff and MD 6/2022 Jane and CL staff report no falls or injury. CL staff continue to assist Jane with transfers in and out of bed and chairs as needed. Jane wears her PERs at all times and is able to verbalize the need for assistance. Jane is using her walker and/or hand rails when walking the hallways	12/2022 Goal met. Continued goal on next year's care plan



Documentation has date and indicates goal is to be continued to new care plan

COLLABORATIVE CARE PLAN TIPS

- ❑ Do not use the word “on-going” as the target date
- ❑ Use the Care Plan as a living document and write updates directly on the document
- ❑ Use in your work with the member throughout the year
- ❑ At member visits bring a copy of the care plan with you to review the goals. This could be a paper copy or a downloaded copy on your laptop.
- ❑ Update care plan goals at a minimum of twice per year & with any health status changes
- ❑ Document the final outcome of each goal

  ***Will it be: Goal met, not met, discontinued, modified, and/or carried forward
- ❑ Be sure to document updates in the Monitoring Outcome and Progress section of the care plan

DHS AUDIT PROTOCOL—COMPREHENSIVE CARE PLAN—GOALS

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Desired Outcome:

The enrollee's goals or skills to be achieved are included in plan, are related to the enrollee's preferences and how the enrollee wants to live their life, and there is a plan to achieve their goals.

Method for measuring outcome achievement

a. Goals and/or skills selected by the enrollee to be achieved are clearly described; **and**

b. Action steps, including services or supports needed, are identified and describe what needs to be done to assist the enrollee to achieve the goals or skills; **and**

c. Monitoring progress towards goals is included; **and**

d. Target dates for goal completion are included (at least month and year); **and**

e. Outcome/achievement dates are included (at least month and year); **and**

f. People/providers responsible for assisting the enrollee in completing each step are identified.

PREVENTING AUDIT ERRORS

- Auditors give you the member sampling list 30 days prior to the audit. Use that time to get your files ready
- Prior to audit, review the CCP. If you completed the goal discussion with the member, but forgot to document it on the care plan, it is OK to do so now. **Caution:** You cannot do this if the goal review did not occur
- If required elements are not completed or are delayed, document, document, document
- If goal progress and outcome documentation is not on the care plan, flag the auditor as to where it is located. If auditor cannot find the documentation you will not get credit
- Electronic records: if progress and outcomes documentation is separate from the complete CCP, be sure to have it labeled for easy identification.

RESOURCES

Blue Plus Care Coordination Web Portal: Care Coordination – Care Coordination (bluecrossmn.com)

On the portal you can find:

** MSHO & MSC+ Community Care Coordination Guidelines

** 6.02.01 Collaborative Care Plan

** 6.02.02 Instructions for the Collaborative Care Plan

** 3428H Care Plan

** 6.28 Transitional Health Risk Assessment

The National Committee of Quality Assurance (NCQA)

Goals to Care. How to Keep the person in "person-centered.: Retrieved from: 20180531_Report_Goals_to_Care_Spotlight_.pdf (ncqa.org)

DHS Person Centered Practices

Retrieved from: Person-centered practices / Minnesota Department of Human Services (mn.gov)

CONCLUSION

In summary, keep in mind as a Care Coordinator you have a powerful role and the potential to strongly influence a vulnerable person's life. Creating person-centered SMART goals is an ART, it can be challenging at times based on each members unique situation, family dynamics but most of all can be very rewarding.

Lastly, I would like to thank you for your time. Please feel free to reach out to your Partner Relations Consultant with questions.