Job Aid

UCare Connect/Connect + Medicare and MSC+/MSHO

Care Coordination and Long-term Services and Supports

Title: SMART Goals

Purpose: To provide guidance for creating SMART goals and define expectations in goal development. SMART goals offer a clear objective to set the member up for success.

SMART	
Specific	• Being specific should answer the following questions: What needs to be accomplished, who is responsible for it, and what steps need to be taken to achieve it? • **Not Specific:** To be pain-free. • **Specific:** Fred will decrease his foot pain score from 8 to 4 within the next year.
Measurable	• Quantifying your objectives allows for tracking progress and identifying completion. Consider measurable verbs; take, perform, complete, use, list, state, self-report, identify, and measurable rates; 3 days/week, 8/10, 10 minutes per day, lab values. • **Not Measurable:** I will have a healthy blood pressure. • **Measurable:** I want to reduce my blood pressure from 140/90 to 130/80 by next review.
Attainable	• Goals should be realistic and reasonable to accomplish. Goals should remain member focused. If your member shares a personal goal that may not be achievable, consider starting on a smaller, more achievable goal to work toward a bigger objective. • **Not Attainable:** Fred wants to be smoke-free. • **Attainable:** Fred would like to reduce smoking from 15 cigarettes per day to 10 cigarettes per day within the next 6 months.
Relevant	• Think of answering the following questions: What is the big picture, why are you setting this goal, is this goal relevant to the "why", what is important to/for the member? Example: A person who regularly gets their annual exam but has a gap in care. • **Not Relevant:** I will self-report completing annual exam. • **Relevant:** I will self-report completing my colonoscopy within 6 months.
Time-bound	• To properly measure your outcomes, your goals should be time-bound. Time-related parameters should be built into your goals. Ask, "When will the member achieve this goal"? • **Not Time-bound:** Fred will lose 10 pounds. • **Time-Bound:** Fred hopes to lose 10 pounds within the next 6 months. • **Note:** MnCHOICES support plans Target Date indicates "when will this goal be accomplished?" Completing this section allows requirements to be met even if the time-bound element is missing from the goal.

Best Practice Tip

Avoid bundling goals (IE, Fred will have his dental/vision and hearing exams by the next review). Unbundling goals will make your SMART goals more achievable and realistic. When you focus on one step at a time, you're more likely to succeed in your objectives. Where your goals are complex and multi-stepped, consider breaking them into multiple goals and focus on 2 or 3 at a time. You can always add more when the initial goals are achieved.

Example

Goal Statement

I would like to decrease my foot pain from 8 to 4 in the next year.

Target Date

When will this goal be accomplished?

08/19/2024

Priority

High

Selected Supports I Requested

Enter a description of the support the person needs to achieve the goal.

Name

Pain Management

Description

My Care Coordinator will provide a list of in-network Endocrinologists. I will schedule and attend an appointment within the next 6 weeks. I will work to maintain a pain log to track my daily pain levels. My wife will provide assistance, support, and encouragement. My Care Coordinator will assist with diabetic footwear and compression socks if needed as well as other medical equipment as needed.

Monitoring progress

Enter a description of the person's progress toward completing the goal. If there is no update, enter the reason or N/A.

4/24/24: Fred is working on establishing care with an endocrinologist. Fred received diabetic footwear which is helping with numbness and pain in his feet. Fred has been tracking his pain levels regularly. Fred ranks his pain at a 6 today.

Status of Goal

In Progress

Status Date

04/24/2024

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FAQ

Q. Do all identified risks from the assessment need to have a goal written on the support plan?

A: If there are identified health and safety risks in the assessment, document on the support plan how these will be addressed with a goal, supports, services, or the member's plan for managing the risk. If there is an identified health and safety need that is important for the member for which the member does not accept intervention, the CC is to document in the "My Plan to Address Safety Needs." See Example below. In the Support Plan – MCO MnCHOICES the system will automatically populate any unaddressed risks or will indicate if all needs are met.

"My Plan to Address Safety Needs" Example: Fred has identified risks due to smoking with a diagnosis of Emphysema and being on continuous oxygen. The care coordinator discussed the safety concerns of smoking in the home while on oxygen and educated Fred on smoking cessation options. The care coordinator provided the number for the Tobacco & Nicotine Quitline and education on using the Quit for Life mobile app. Fred declined a tobacco cessation goal at this time but may consider it in the future.

Q: Do all my goals need to have the same target date?

A: No. They should be member-focused and what makes the most sense and is agreed upon between you and the member. Goals that can be achieved in less than a year would have a target date that reflects the realistic timeframe for which the goal can be met.

Q: Can my target date exceed one year?

A: No. The target date should not exceed one year. If the goal is not achieved and the member continues to keep it, the goal is continued in the new support plan with updates as needed. Discuss why the goal wasn't achieved and what needs to change to have a successful outcome.

Q: What are canned goals?

A: Canned goals are generic goals created to fit any member and are not person-centered. Canned goals are often applied to every member's support plan. UCare does not encourage the use of canned goals.

Q: Is there one way to write a SMART goal?

A: No. SMART goals can be subjective and rely on what the assessor knows and observes about the member and their situation. What is attainable for one person, may not be for others.

Q: Should I use the member's name or "I"?

A: The member's name or "I" meet the person-centered approach. Either are acceptable.

Q: What is the best way to create goals when the member cannot verbalize their wants/needs?

A: It's best to discuss what the member prefers first, and utilize alternative decision makers (IE: Guardian, caregiver, responsible parties) for additional member information. Consider the example goal:

John's guardian will ensure he completes his annual eye exam within 6 months.

Q: What is a good way to create a goal when a member will not state any goals?

A: Utilize motivational interviewing techniques by asking open-ended questions to encourage the member to expand and create at least one goal. Consider reviewing identified risks and re-frame thoughts (IE: What is important to you this year? Or What would make your health better?) to encourage at least one goal.

Additional SMART goals resources:

1. SMART Carte
2. Smart Goals Training