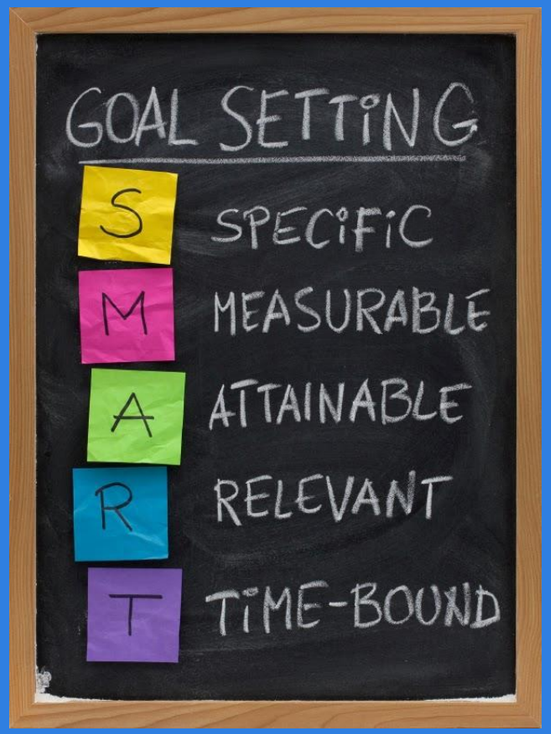
Creating SMART Person-Centered Goals



Objectives

1

Understand the SMART acronym and how to apply it in your care planning practice

2

Learn techniques to convert identified needs into SMART person-centered goals

3

Identify common pitfalls when creating SMART person-centered goals

Policy Drives Person-Centered Approaches

CMS and DHS

- CMS Home and Community-Based Services Rules
- Minnesota Statute 245D
- Americans with Disabilities Act (ADA) and the Olmstead decision
- Minnesota’s Olmstead Plan

Person-Centered Concepts

"The individual's goals should drive care coordination, but to be effective, person-centered care management also requires effective communication and coordination amongst the individual, their health care providers as well as paid and unpaid supports." -National Committee for Quality Assurance (NCQA)

Care Coordinators (CC), responsible for helping members with their medical and long-term service and support (LTSS) needs, must understand what is most important to the members

CCs must also have an effective system for supporting members preferences and goals when coordinating care with others supporting the member. The CC is often at the center of HOW that care is coordinated.

Pitfalls of Creating Goals

Members who are not used to thinking in terms of goals may find this challenging

Members focus on negative issues

Members desired goal may not be attainable or realistic

Care plans have too many goals

Goals are ‘canned’, not individualized, without member specific supports or interventions listed

Carrying over goals from year to year without close review and updating

Using abbreviations and clinical language that the member may not understand

There may be barriers to achieving the goals

Developing SMART Goals

SMART goal development was developed by George T. Doran

- Specific
- Measurable
- Attainable
- Relevant
- Time-Bound

Writing a SMART Goal:

Specific:

State the goal clearly; use a person-centered statement

"I would like to stay in my home"

Not Specific

Using Motivational Interviewing Techniques is a great way to elicit goals and get **Specific.** Care Coordinators need to help members articulate their goals.

Writing a SMART Goal:

Measurable:

What	How Measured
Smoke no more than 10 cigarettes per day	Self report
Improve mental health by sleeping 4-6 hours/day	Self report
Congestive Heart Failure to remain stable by not gaining more than 5 lbs in 3 days	Clinic records; self report

Measurable Goal:

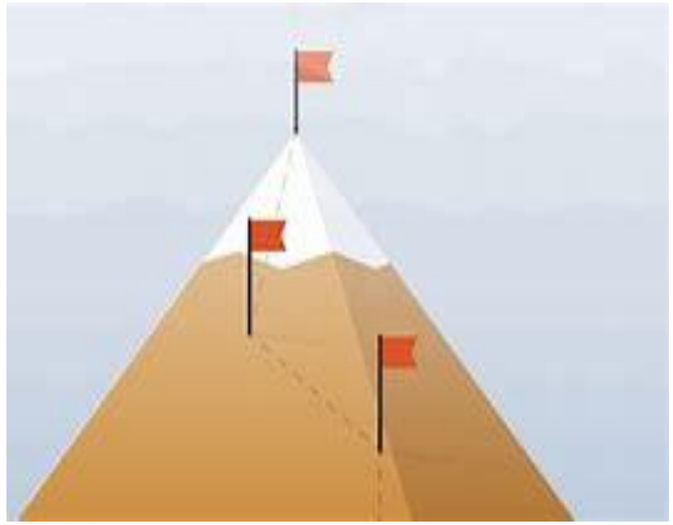
Rank by Priority	My Goals	Support(s) Needed	Target Date
☐ Low ☒ Medium ☐ High	Sam would like to improve his mental health by sleeping at least 4-6 hours per night	-Sam will take sleep aid medication as prescribed. -Sam will go for daily walks to help with his sleep. -Sam will not drink coffee past noon -CC will provide information on mental health supports and refer as needed.	9/30/19

Measurable Goal

Writing a SMART Goal:

Attainable:

Break the goal into smaller, actionable steps. Identify expected barriers and decide to address them.



Not attainable – attainable goal

Not attainable	Attainable
I want to be smoke free	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 would like to smoke no more than 10 cigarettes per day	-Sam wants to schedule an appointment with his doctor about smoking cessation aids. -Care Coordinator will provide information on health plan's smoking cessations programs. -Sam will take over-the-counter products or medication as prescribed by his doctor. -Sam will go for daily walks to feel healthier	9/30/19

Attainable Goal

Actionable Steps

Writing a SMA**R**T Goal:

Relevant

Make sure the goal reflects what's important to the individual. Use Motivational interviewing to help tie identified needs from the assessment to goals.

- Why is this goal important to the member?
- How will this goal benefit your member?
- Will the member stay committed to the goal?

Writing a SMAR**T** Goal:

Time-Bound:

Define the period in which the goal is to be attained and agree when to check progress.

Is this a long or a short term goal	Prioritize by importance, put “first things first”	Schedule the time to follow up reviewing progress	Are there things that could prevent goal from being completed

Supports and Interventions

- Document any intervention(s) related to achieving the goal
- What will the member need to accomplish the goal
- Who will help the member achieve the goal
  - Formal/informal supports
- Can have multiple interventions for one goal

Supports and Interventions: Examples

Sam’s daughter will remove scatter rugs throughout the house

Sam’s sister will attend doctor’s appointments with him

Sam’s home care nurse will visit weekly to fill his medication dispenser

Sam will use a safety pendant to alert family if he falls

Sam will schedule an appointment with a dietician at his clinic to discuss nutrition and meal plan

Care Coordinator will provide smoking cessation information and mail to Sam

Goal Creation: Tips and Tricks

Build trust

- Respect the individual's preferences

Listen for cues i.e. excitement about a topic, comments about current struggles or reflections on the past

Motivational Interviewing techniques

- Open ended statements
- Reflective statements
- Summarize

Use Person-Centered language including:

- Members name or I statement. Refrain from using "Member"
- Would like to, wants to, etc. Refrain from using "will" or "should"

Goal Creation: Tips &Tricks

Gather	Gather information from the Health Risk Assessment to prompt a goal
Help	Help the member break down broad or vague statements into attainable goals
Being	Being able to craft the answer to express what the member wants yet meet requirements
Encourage	Encourage goals that have the potential for positive health and quality of life outcomes
Promote	Promote self-advocacy and self-realization. Help the member find their ‘can do’ attitude. “You are your best advocate”
Identify and address	Identify and address barriers
Avoid	Avoid Clinical language (PCP, CC, PRN, CHF, SNV, HHA, etc.)

Pulling it all together

Not SMART vs SMART Person-Centered Goals

Not Smart or 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 15 pounds within the next 6 months
Member will be compliant with high blood pressure medications daily	Sam would like to take his high blood pressure medication every morning for the next 12 months
Member will be free from falls	Sam would like to be free from falls for the next 6 months

Questions?