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SMART Goals - Frequently Asked Questions (FAQ)

1. How do we create these goals when we are required to create goals that match the services we are authorizing?
The services authorized should be reflected on the Care Plan, they do not necessarily need to be in the goals section (reminder, service agreement is part of the Care Plan) as a stand-alone goal just for service. Goals should be based on members identified needs on the HRA. The information gathered on the HRA should support the services you have set up to meet the member's needs. The services may be included in as specific interventions and/or on the service agreement. An example of this may be a member that is at risk for choking and intervention may be that the Personal Care Assistant (PCA) will monitor the member for choking at all meals. If PCA is identified as managing behaviors, what is that PCA doing? Is PCA redirecting, removing from harmful situation. This would be more than listing the # of hours as that is on the service agreement.

2. I thought we are supposed to be Member Centered by using their name? That is not the case anymore?
Yes, you are correct, the members name or I is more person centered. All goals should be written in person-centered format.

3. For clients with Alzheimer's/Dementia and we have to go through family members to discuss goals, how can we get measurable and relevant goals for the member? Ex: Member wants to travel again, but that's not achievable due to health. Family member wants member to be able to be present to enjoy conversations with family and friends while in the memory care. How can I still make the goals SMART and person-centered?
Negotiate and discuss goals with the member first, then collaborate with family to determine appropriate goals. Think outside of the box, maybe the person cannot travel because of health conditions, but maybe the memory care could incorporate a picture book of places the member identifies.

4. Isn't not having any ER hospitalizations measurable?
This can be measurable if you have a target date and add that the member "will self-report no hospitalizations or ER visits". Also, this particular goal was discussed with Dr. Jody Nelson at Medica. Her suggestion was to stay away from this blanket goal and try use a goal more specific to the member. Why was member in ER? Does a goal need to be created around the "why" with interventions that support readmission based off the reason the member was admitted.

5. Most of my members state they have no goals. Am I supposed to be creating these goals for these members if they don't have any? If this is supposed to be member centered, is me making a goal for them, really person centered?
For these members you really want to rely on your Motivational interviewing skills to elicit goal participation from the member. Reframing your question about goals, instead of asking "what

are your health goals/personal goals for this year, maybe ask "what do you want to work on"? It also is helpful to use results of your HRA to help guide conversation about a possible area to work on. For example, the member stated that he has not had a colonoscopy yet, and he's not really sure that he wants to have one. You could ask the member if he would consider talking with his doctor about this at his next visit, or that he will make an informed decision about having a colonoscopy. Another possible goal for these types of members would be: I will contact my Care Coordinator if I have any needs by the next review.

6. Our non-English speaking member will not be able to specify like these example you give.
When working with our non-English speaking members it is feasible to create specific goals, however only asking the member "what are your goals" may lead to confusion by the member. Asking questions such as "what is important to you this year? What do you want to accomplish? What things make you happy? When you reported that your health is just ok, what would make your health good, or great?

7. I struggle to help member's /define/ goals. Most of my members' goals are related to things that I've identified during the assessment: They're past due for a tetanus shot, need an eye exam, etc. But when asked directly about self-identified goals, the responses are most often very vague: "I don't know." or "I just want to be as happy and healthy as I can". Do you have any suggestions for how to come up with goals for these members?
Yes, a great way to elicit a goal from a member when they are unsure of a self-identified goal is to circle back. For example- "remember when you said that you were past due for a tetanus shot and eye exam, would either of those be something you would work on this next year?" Another angle for this particular member would be to ask: what are the things that make you happy? What does good health look like for you? Does it mean less trips to your doctor, higher stamina, or better sleep?

8. Will the Corrective Action Plans be on audits for both MSHO and for SNBC?
Yes, Corrective Action Plans will be issued in 2021 Audits of MSHO, MSC+, SNBC, ISNBC for all charts created after 9/1/2020.

9. I prefer the phrasing would like or want for goals and not will. We were taught that will was a strong statement.
Great idea, that is a great way to make goals more person centered. Both are acceptable ways to write a SMART Goal.

10. How do we develop goals when the member has an unrealistic goal? For example, I have an elderly woman who wanted to put a goal in for finding a husband. Obviously it's probably unrealistic (especially in a year) but how do we not include it when we are to be person centered?
Using our motivational interviewing skills, we need to try and get to the core of what the member is wanting. In this particular example the member is really asking for human connection and sounds lonely. Check this out with the member. You say you want to find a

husband in the next year, why is that? A goal that you could possibly use in this situation is: Name, I will self-report going to the Sr. Center 1 x week to meet new people.

11. Is there a requirement to have at least one high priority goal?
Yes, more information can be found in the CCP directions document.

12. Could you provide some examples of measurable mental health goals that are member centered?
(Member name,) will be able to list at least 3 coping skills by their next review.
(Member name,) will establish care with BH therapist by target date.
(Member name,) will self-report taking medications as prescribed by Provider by their next review.

13. What if the goals the member identify do not match the services authorized?
The services authorized should be reflected on the Care Plan, they do not necessarily need to be in the goals section (reminder, service agreement is part of the Care Plan).

14. If member just keep saying "I don't know" or "I don't have any personal goals" and ask you to move forward. How much should you keep asking for a goal? Can you just document it if members are declining goal on Care Plan?
I would encourage you to try and have the member expand on this. Giving some goal examples is a great way to negotiate a goal. You will also want to use information that you have gathered from your assessment. For example you could say, I hear you saying that you don't have any personal goals, we did talk about how you haven't seen your Doctor in over a year, would that be something that you would want to make a goal for this year. Per the Collaborative Care Plan instructions members should have at least 1 "active" or "open" goal on their care plan, and the target date should extend to the next annual assessment.

15. Is it best to have the goal simple rather than add under annual exam: pap, mammogram, flu shot, etc?
Yes, these should all be listed individually. Member will have an annual exam. Member will have a mammogram. Remember that we should be un-bundling goals, and having the member lead with what they would like to work on over the next year.

16. If a member is on hospice what are some good examples of goals? I know comfort is usually a top priority. Would that goal suffice or would more goals be needed?
For these members, we recommend focus on Member specific goals, and collaborating w/family as well. It is okay if their top priority is comfort and controlling pain. Some goal possibilities for members on hospice:
I will self-report taking my pain medication as prescribed by my Provider by the next review.
I will self-report acceptance of hospice visits by the next review.
My family will accept hospice support by the next review.

17. You say that the goals have to be what the member wants but we are told that we have to have goals for services the member has. Example PCA, Hmking, Assisted living.
The services authorized should be reflected on the Care Plan, they do not necessarily need to be in the goals section (reminder, service agreement is part of the Care Plan).

18. Can you address clients whose only goal is to remain in their home despite concerns about their ability to remain home alone i.e. dementia, physically at risk, not eating well etc.
Yes, this is a great time to talk through with the member "What things will help to keep you in your home? What services can keep you in the setting that you want? Lifeline, family support, PCA, homemaking, Adult Day, these are all possible services and supports that could help the member meet their goal. Self-preservation or safety goal would make sense here. Example: Member understands risks of refusing services and will notify Care Coordinator by target if needs are not met.

19. Isn't doing Physical Therapy more of an intervention for a goal such as... to be stronger or be able to walk further?
It can be both. Example: I will complete physical therapy by Oct 1st. or I will self-report increasing the distance I am able to walk with my walker from 5 feet to 25 feet by the next review. In the second example the Physical Therapy would be the intervention.

20. Is there still a requirement that all identified needs need to be carried over to the care plan, and do all identified risks from the LTCC need to be addressed on the CCP with interventions?
You are correct, all identified needs do need to be carried over to the Care plan. This is still a requirement. If a member declines a goal or intervention that does need to be clearly reflected in your documentation.

21. Can you clarify what the requirements are for when the care plan needs to be updated? Is it that the care plan has to be completed at least at the 6 month time frame from the HRA completions or that it needs to be completed not less than once every 6 months? For example I complete the HRA 6/1 and update the CP 8/1 due to changes. Is the next CP update required by 12/1 or is it not by 2/1 which is 6 mo from the last update.
Care plan needs to be created at Annual HRA time, and with any changes in condition, services, or supports. Medica's minimum requirement is every 6 months. CC's are encouraged to update as things occur as this is a "living document". In the above example by completing follow-up early you have met your follow up plan you identified and if the goal was met or changed. You will want to ensure that all goals on care plan were addressed within that 6-month follow-up period you indicated. If you have addressed all goals during the 8/1 update, the next follow-up is due no later than next scheduled reassessment (which would be prior to 2/1).

22. When member does not want a goal where is the best place to document that?
You would document on the CCP either in the section titled "Managing and Improving My Health" or the CC can indicate this on the HRA itself where the identified needs is indicated. You

can add it on the safety plan- especially if it is a safety concern. (Per care plan instructions: If the CC offers a service that is critical to the member's health and safety that is not accepted by the member, this should be noted in this section).

23. I thought that the goal section itself had to have the time element inside of it (not just in the target date section).
You do not need it in two places. The goal itself needs to be measurable to be SMART, but the target date section meets the requirement.

24. Do we still need to state whether or not a goals was achieved including whether the goal was to be continued or discontinued. Could you clarify?
Yes, you still need to state whether or not the goal was achieved including whether the goal will be continued or discontinued. Per care plan instructions: You need at minimum, include the final outcome of each goal at annual reassessment (e.g., goal discontinued, modified, or carried forward to next year's care plan).

25. If there is a need identified on the care plan then that needs to be put in as a goal correct?
Correct, if there is a need identified on the HRA, a goal needs to be created, or the CC needs to document why it was not. (Member declined, etc.)

26. Is it required to state "I will self-report"?
No, this is not a requirement. This is an example of how you may measure the goal. There may be other times when the measurement is not a self-report type situation depending on the actual intervention.

27. Could you please provide more examples for members with dementia and in memory care that are unable to verbalize goals?
Sure, I will be sure to include some examples in the next session. Some tips in this situation are to negotiate and discuss goals with the member first, then collaborate with family to determine appropriate goals. Think outside of the box, maybe the person cannot travel because of health conditions, but maybe the memory care could incorporate a picture book of places the member identifies.

28. How does creating a goal that states "I will self-report any falls to my CC by next review" help to change a behavior or improve a client's risk of fall?
This depends on what goal is determined by the member. In this instance that may be the goal, if the member were to self-report a fall, the CC may need to assess the cause of the fall and determine if the interventions need to be updated. Maybe the CC needs to add in a lifeline, cleats for walking no ice, or readdress removal of throw rugs (as examples).

29. For dementia/cognitively impaired individuals, stating "I will self-report" doesn't sound applicable. Suggestions?
I will self-report is not a requirement of SMART person centered goals, it can be used as a way to measure a goal. In these instances you could also have a family member reporting, or Nursing Facility staff.

30. What if we wish to help a member not have falls, but we are not the ones scheduling the home safety evaluation?
Home safety evaluation is an example of a potential intervention. Maybe the CC is not scheduling it, but are they coordinating it with OT/PT? Maybe a Skilled Nursing Facility scheduled it prior to discharge. Did they recommend this to the member and the member is scheduling it on their own? The action step (intervention) can be completed by a multitude of people. This should indicate what is being done to attempt to address the goal.

31. If a member doesn't feel they want a goal for something - do we need a lengthy explanation as to why the member declines having a goal or is "member declines?"
You would document on the HRA or on the care plan itself where the identified needs is indicated that the member does not want a goal or declines. You can add it onto the safety plan- especially if it is a safety concern. (Per care plan instructions: If the CC offers a service that is critical to the member's health and safety that is not accepted by the member, this should be noted in this section). CC's should use motivational interviewing to determine why an identified need may not justify a needed goal to the member.

32. Do we have to list what ADL/IADLs the PCA will help the client with in the PCA goal?
The information gathered on the HRA should support the services you have set up to meet the member's needs. The services may be included in as specific interventions and/or on the service agreement. An example of this may be a member that is at risk for choking and intervention may be that the Personal Care Assistant (PCA) will monitor the member for choking at all meals. If PCA is identified as managing behaviors, what is that PCA doing? Is PCA redirecting, removing from harmful situation. This would be more than listing the number of hours as that is on the service agreement.

33. Would a good diabetic health goal be "I would like to lower my A1C to under 7 by next review" and then add the supports/interventions of how they would achieve that?
This could be a possible goal depending on what the physician has stated is the members A1C target. In this case, the interventions would be how to achieve this A1C which may be around scheduling lab appointment, obtaining nutrition counseling, starting exercise program, the interventions are endless.

34.You had stated in the example that listed a bunch of goals that we did not need to work on all of those goals but I thought if a need was identified on the care plan then we need to put a goal.
The member can determine what goals are priorities to them. If a goal is not a priority, and the member declines it at this time the CC can indicate this on the HRA or on the care plan. If the member wants to proceed with addressing this identified need at a later time, the CC can document the care plan (which is a living document) to reflect this goal addition/modification when the member determines they are ready to work on that goal.

35. Is the expectation to change the target date throughout the service year or is it ok to make the target date a year out?
Target dates should be based on the member's assessed needs. These timeframes will vary. It may be 1 week, 1 month, 3 months, 6 months, or 1 year out.

36. Can you give an example of a member who knows they need to exercise and eat healthy but indicates she lacks motivation? How can I create a goal that is realistic that she would be willing to do or buy in? She has no desire for goals... Thanks, please note my member is 74 years of age.
It sounds like the member may be overwhelmed at the broader goal of eating health and exercising. Start small, make the goal attainable, this member may not need to be in work out program. Maybe they will walk 50 feet in the hallway, maybe they will walk from their bed to their couch 3 times a day, maybe they will stand during every TV commercial. Another way to address would be to dial in on the member's lack of motivation, and see what that really is about. You say that you lack motivation, why is that? Is there anything that does motivate you?

37. One of my members was hesitant to make her goals much more specific and wanted to leave goal more general so that she can pursue goal at her own pace and as she is able. Should I leave the goal as a general goal?
That depends on what the general goal is. If the member is wanting a more general goal that is ok, you just want to make sure that it's in the SMART format and that you are able to measure it.

38. My question is about the goal that was an example "I will receive PCA and Lifeline" for the male who was non-English speaking. I'm struggling to understand how that is a goal since it is just a CC setting up services. Shouldn't it have been re-written to show what the services are helping to achieve?
In the case of a new service being set up for the member it is appropriate and member centered for this to be a goal, especially if this is an instance in which the member is wanting to find their own PCA. Remember that in the example this was a goal that the member wanted to work on.

39. We contact our members every 6 months so would check on goals at that time.
The care plan is a living document. Medica's minimum follow-up requirement is every 6 months. You will need to consider earlier goal check in if your target date is prior to the 6 month follow-up. This should be based on the member's needs.

40. To use the example of falls: Is the expectation now that we would make a "Don't falls goal" and then also "Get a cane" goal or can we have a "avoid falls" and then intervention is to get a cane?
You need to consider the members specific goal. Is it to not fall or to get a cane. If it is to not fall, interventions should be what you have in place to prevent falls, which may include getting a cane. If it is to get a cane then the intervention may be to provide them with a choice of DME providers, assist in coordinating an OT evaluation to determine what is needed for the member, order the cane, etc.

41. If a member needs equipment or supplies in the middle of the year are we to add goals in for all supplies/equipment they want/receive?
If the members needs have changed, you need to determine if there was a change in condition, if so, a new assessment needs to be completed. If the member needs a change in equipment or supplies, the goal and/or service agreement should be updated to reflect what is needed.

42. Is it correct that we need a goal that relates to every service on the service auth.? If so we could have a lot of goals whether the person wants it as goal or not.
The services authorized should be reflected on the Care Plan, they do not necessarily need to be in the goals section (reminder, service agreement is part of the Care Plan). A service should not be started if the member does not have an identified need or want the service.

43. If our members have been receiving PCA/HM and other services for many years, they have no issues with them, nor do they want to change services --Does this mean that that does NOT need to be a goal since they are not wanting to work on/change anything?
The services authorized should be reflected on the Care Plan, they do not necessarily need to be in the goals section (reminder, service agreement is part of the Care Plan). If the PCA has specific interventions they do for individuals like a behavior plan, or monitoring for safety concerns it would be good to create a goal around this identified concern specifically.

44. Where in the care plan would you like Preventative Health Care measured and addressed in the care plan?
There is a section on the collaborative care plan (MSHO/MSC+) called Managing and Improving My Care and on the SNBC & ISNBC care plan called Health Prevention/Chronic Condition. This is where you would indicate if educational conversation occurred re: preventive health. It is helpful to include in the notes/comments section information provided or why a goal may not be needed. You need to indicate if a goal is needed or not needed for each element. If a goal is needed you would carry it over to the goal section and create a person centered, SMART goal, with action steps & individuals involved for each step, as well as a target date.

45. This will require more information to be added to the care plan. Has there been any discussion about updating the goal section of the care plan to make it easier to follow? Specifically: the more information added to a column the longer the document becomes and it's hard to follow, horizontal areas to fill instead of vertical columns?
Monitoring notes do not need to document entire conversation, but should address the status of the goal, intervention effectiveness & modifications that are being made. We are updating the care plan and have included an area for more extensive notes after the goals.

46. Do we need to specifically then note "no goal needed" then for that list of "managing and improving my health"?
Yes in this section it needs to indicate if goal needed or not needed. (In addition to educational conversation if this occurred).

47. Will the upcoming collaborative care plan that is to pull information from the LTCC directly pull goal information over to the care plan or will that be information we will need to enter in to the care plan? Okay. I wanted to know if those 'goal' area questions in the LTCC if we would need to use the SMART goal wording in those areas. Might just do that to copy/paste.
We have not yet seen the final version of the auto filled care plan that DHS is creating to pull from the LTCC (3428) only. This will not pull for the 3428H. It is our understanding the program will pull data, but the CC will still need to make the goal person centered and SMART. Once this is finalized there will be a training provided, so expectations are known by all that will be using it.

48. How are the goals (in which the caregiver takes action considered a goal for the client? I would consider that a recommendation for a caregiver and not a goal for the client. I would usually case note and not create a goal on the care plan for this.
Support of the caregiver is necessary in meeting the member's needs. Caregiver burnout may be a barrier to the members needs being met. We would want to address the barrier.

49. Can you please clarify the medication goal in the Collaborative Care Plan about if they need support then a goal needs to be written. What if they are in an Assisted Living or Adult Foster Care?
On the care plan where it states "I need help with my medications", if the members medication needs are already being met by Customized Living or Adult Foster Care staff, this box should be marked "no" as a goal is not needed.

50. In the example given with a blood sugar testing goal: it said I will test my blood sugars "as recommended by PCP." Does it not need to be specific to state how often? I just was looking to get at the specific piece of a SMART goal and what the expectation is for auditing.
The goal should be written to meet the needs of the member. If the member indicates they will test as recommended by the PCP that is an adequate goal statement. A good time to use this would be if their frequency of testing if often changing, as long as the member knows what the expectation is. For others, the goal may read I will test my blood sugars daily, twice daily, etc. Either would be acceptable.

51. How can it be respectfully documented on care plan of a member who lives with Obesity - who doesn't want weight loss as a goal? Or if member doesn't want wt. Loss as a goal, - does it have to be mentioned on care plan?
Weight loss may not be the only goal option for a member who lives with obesity. Your goals should be based off identified needs not necessarily a diagnosis, consider how the members quality of life and ability to perform ADL's and IADL's is impacted & discuss goals around these areas versus a goal for weight loss with the member. If the member chooses not to have a goal around an identified need, document that.

52. How should we word goals when the member is not able to verbalize goals and has a guardian but lives in a group setting where the staff are much more involved in member's care than the guardian? Is "Caregiver will report" appropriate?
Yes, "Caregiver will report" is appropriate. Another option could be the "Guardian will report."

53. Should a goal be continued or ongoing for members with chronic pain?
Whether the goal is ongoing/continued is dependent on the member and their needs. For example, if a member's quality of life, ability to complete ADL/IADL's etc. is compromised because of their pain; a goal addressing the need is necessary. If they come to a place where their chronic pain is well managed and interference in their life is minimal, then a goal may not be needed. The pain section on the LTCC lets you tell that story, and whether a goal is needed on the CCP.

54. Will goals written before 9/1 need to be changed by 9/1 if not written in this way? Or is it OK to wait until next HRA to re-write goals?
Goals created after 9/1 will need to be written in SMART format. It is not an expectation that you go back and re-write goals from previous care plans. The expectation is for all goals going forward.

55. If I set a Target date for November and I was unable to reach member. What should I chart and should I continue goal?
Document your attempts to reach the member. If you are unable to reach the member or unable to confirm if the outcome has been reached (example: you saw a claim for an eye exam or mammogram, etc.) the goal should be continued as the outcome has not been met.

56. There are many chronic issues that members have including falls, pain, MH (not wanting to see MH provider or does not need). Stable goals such as "No falls" will continue from year to year. Some of these members CC's have had for many years and we can provide suggestions but if the member does not want anything different we cannot add it to the care plan. Hard to be creative with these folks after so many years.

You are correct several of the identified needs are chronic, consider if the goal is being met or being closer to being met. If it is not, maybe you need to visit with the member about altering the interventions to work towards a more positive outcome. (Example: Member will have 0 falls. Member had 2 falls, determine cause of falls and make adjustment to interventions specific to prevent reoccurrence).

57. Our CC's work with multiple health plans and have been asked to write goals differently by the other plans. Is there potential for all the plans to collaborate on goal writing so the expectations can be consistent for all? For example, UCare gave a presentation recently and said goals similar to your example "» Will accept grab bars in their home by the next review" would be considered an intervention. They also specifically asked to have the time frame included in the goal itself.

I can see the grab bars part as a goal in itself or as an intervention say in a fall goal. Regarding the timeframe, the use of a target date is a new concept for Medica, in the past we have said to be measurable it must be separate from the target date, this is not the case anymore. When using target date in this way, target dates should reflect real time based what the need is. For example, if the goal is requires purchase of a walker, the target date may be 30 days, or whatever time is realistic to get a walker for the member. In the past, we have often seen target dates to be always one year out, which will need to change with this method. It's important to note your auditor will continue to work with you on SMART goal documentation. It's a work in progress for all of us.

58. What should we do if we run out of space to add more goals? The document itself is locked to edit. The problem we are running into is with the new idea of not having overarching goals and separating them into individual goals to be more measurable.

Currently there are spaces for 7 goals on the Collaborative Care Plan. We encourage you to talk with members when creating goals about which goals will be their priority to work on. More than 7 goals may be overwhelming for a member; and as such you may need to work with them to choose the goals that are priority initially, and update as the year goes on. Clear documentation about which goals were selected and why will help show an auditor why something on the LTCC wasn't initially listed as goal. With that said, we understand there will be times either at the initial care plan creation or during the year as you continue to update the care plan that you will need more space. Medica will create a goal addendum page which will allow you to attach a second page of goals to the care plan document. This will be posted to the CC website.