Overview

The Needs, Outcomes, and Goals are made based on the participant's services and their personal goals. There must be a Need, Outcome, and Goal for each service (except Service Coordination*) until you run out of available Needs/Outcomes/Goals. If you have a N/G/O for each service and there is additional room, then the participants personal goals should be listed.

Needs

Details why the participant *Needs* the service or what they need help with specifically requiring the service. Always ask the participant "Why do you need this service?" or "what does this service help you with?"

Examples

These are meant as a guide to the format of the Needs.

PAS

Why does the participant need a caregiver/what is the caregiver going to help them with?

- Ms. Amcord needs to eat diabetic appropriate meals to prevent hospitalizations for high glucose levels
- Ms. Amcord needs to take her medications as prescribed
- Ms. Amcord needs to improve mobility
- Ms. Amcord needs to improve personal hygiene
- Ms. Amcord needs to decrease hospitalizations related to falls that take place while completing bathing, dressing, and ambulation

PERS

Why does the participant need a PERS unit/what will the device do for them?

- Ms. Amcord is unable to dial her phone due to arthritis and needs to be able to access EMS as needed
- Ms. Amcord needs to be able to attain assistance from EMS should a fall/injury take place

HDM

Why does the participant need home delivered meals/what will the meals provide them?

- Ms. Amcord needs to better manage her health through diet and nutrition

- Ms. Amcord needs to better manage her diet and food portion intake
- Ms. Amcord needs to have access to 2 meals per day to maintain her physical well being
- Ms. Amcord needs to prevent hospitalizations due to high glucose levels

ADC

Why does the participant need to attend ADC?

- Ms. Amcord needs to improve her socialization skills
- Ms. Amcord is diagnosed with dementia and needs constant supervision and assistance with bathing, dressing, and toileting throughout each day
- Ms. Amcord needs to improve her depression and anxiety

Status of Need:

Met: This indicates that the Need is already being addressed fully, through either informal, formal, or a combination of both types of assistance.

1. If there is already a service in place (ie. PAS) to meet the need and there is no area of the need being unmet, then you would select “met”
    a. Ie. Participant has PAS provide verbal reminders during shifts to take medications, participant is taking medications 100% of the time.

Partially Met: This indicates that the Need is only partially met at the time of assistance

1. If there is already a service in place (ie. PAS) to meet the need, but it is not fully met, then you would select “partially met”
    a. ie. Participant has PAS provide verbal reminders during shifts to take medications, but the participant is forgetting to take medications during times when PAS is not present.
2. Service Coordinator should ensure a service is put into place to meet the need moving forward

Unmet: This indicates that the Need is unaddressed by either formal or informal assistance at this time.

1. If there is no service in place yet and the need is not met OR there is a service in place but it is not meeting the need, then you would select “unmet”.

a. ie. Participant has no services yet that assist with medication reminders and is currently forgetting to take medications each day, the participant does not have family or friends to assist.
b. Ie. Participant previously wanted PAS to remind them to take medications daily, but the participant wants the PAS schedule to be at times when the participant would not be taking medications. Participant is currently forgetting to take medications and does not want to move the PAS schedule.

2. Service Coordinator should ensure a service is put into place to meet the need moving forward

Outcomes

Details the *Outcome* on the participant's life/health/well-being if the *Need* is satisfied.

Always ask the participant, "What are you hoping to achieve by satisfying the previously stated need?"

Examples

PAS

If the need was "Ms. Amcord needs to improve personal hygiene" then how will improving the daily hygiene affect the participant's life/health?

- Ms. Amcord is attending church on Sundays and going to her local senior center on Tuesdays and Thursdays each week, now that her hygiene is improved
- Ms. Amcord will improve her personal hygiene and will be able to go to activities in the community, such as bingo and church.

PERS

If the need was to have access to EMS in the event of a fall/injury, how will having this constant access help/benefit the participant?

- Ms. Amcord will have access to EMS 24/7
- Ms. Amcord will receive prompt care/treatment of injuries, reducing the long-term impact with quick access to contact EMS in the event of an emergency.

HDM

If the need was “manage her health through diet and nutrition” then how will improving diet and nutrition affect the participant’s life/health?

- Ms. Amcord will have a reduction from 4 to 2 hospitalizations in the next year
- Ms. Amcord will lose 10lbs in the next 6 months, with pre-made, pre-portioned, nutritious meals.

ADC

If the need was “to improve socialization” then how will increased socialization help the participant in life?

- Ms. Amcord will have socialization opportunities with her peers Monday through Saturday each week for the next year at the ADC
- Ms. Amcord will be able to participate in activities she likes doing with her peers, such as bingo and arts/crafts, while at the ADC Monday through Friday each week

Goals

Details the participant’s *Goal* in having, receiving, or utilizing the service to satisfy the *Need* for it and obtain the desired *Outcome*. All Goals have to be SMART, meaning it must include statements pertaining to each letter of the SMART acronym.

Get S.M.A.R.T details from the participant/responsible party! Do **NOT** try to complete this without participant input.

1. Start with a basic goal for the service such as:

Hint: this can or likely will be similar to the NEED of the service

- Prevent hospitalization
- have assistance in case of falls or emergencies
- improve socialization
- improve diet/nutrition
- continue living independently

2. Go through each letter of the SMART acronym to add onto the goal

S – Specific

The goal must be clearly stated and detailed using person-centered statements. When reading a completed goal it should have information that is relevant to only this particular participant.

Ask the ptp: “What causes the need for help?” (ie. is there a specific diagnosis or symptom that makes it difficult for them to complete the task), “How will the service assist you with reaching the goal” (ie. participant might say they need hands on help with some aspects of the task and maximum help with others)

Goal example: To receive assistance with bathing and personal hygiene

Specific example:

- I need help because I have pain in my knees and shoulders from my arthritis and I need someone to help me get into the shower chair and then wash my legs, hair, and back
- I have MS and some days I am weaker than others, at minimum I need help getting in the shower and setting up everything for me to wash myself
- I keep getting infections in my wounds, so I need help so I can bathe every day

M – Measurable

The goal must have Definable/Quantifiable supports for when/how often the goal will be done

Ask the ptp: How often/when do you need to do the goal?

Goal Example: To improve socialization by going to the community/senior center more often

Measurable example: ask the participant how often they’d like to go to the community center and their answer could be something like:

- I want to go to bingo every Tuesday night
- I want to go out twice a week to the Senior Center

A – Attainable

The goal needs to be realistic for them to complete. Make sure it is realistic to the participant’s capabilities. For example, a participant might say they want to lose 80lbs in the next 6 months and their doctor has told them 20lbs is a more reasonable goal.

Goal example: to lose 20 lbs in the next year by eating HDM’s and decreasing sugar intake

Attainable check example: Confirm the participant's current weight, if this is all that's needed to lose the weight, and if a physician agreed this would be able/safe to be done. Things to consider:

- A participant that only weighs 200 lbs might not be able to lose that much weight
- Exercise may also be needed for a participant to lose weight
- A physician may feel that HDM won't be able to provide enough nutrition to a participant or that the weight loss the participant would like to lose is not a realistic amount

R – Relevant

The goal must be relevant to what the service actually can provide.

Things to consider:

- PAS providers/HHAs provide assistance with ADLs and IADLs. They aren't responsible for improving mobility, but they could remind a participant to do their PT exercises each day
- PERS units provide access to calling EMS. They can't prevent falls or help a participant walk, they are only to gain access to assistance.
- HDM provides pre-made meals. It is not necessarily going to help the participant lose weight.
- Transportation gets participants to and from appointments, they do not remind the participant to schedule or attend appointments.

T – Time bound

There must be a timeframe for completing or reassessing the goal, they are updated at each visit. Ask the participant if this is a long term, or short term goal, when they would like it to be completed by, or when we should reassess the goal to either continue it, or change it. There should be a reasonable amount of time to make progress or complete the goal.

Goal example: to have assistance if a fall occurs when they are home alone.

Timebound example: ask the participant how long they intend on having the PERS unit

- for the next 6 months
- for the next year

3. Pull all the information together to make the SMART goal

EXAMPLES:

PAS example: Goal is to have help with bathing, dressing, and grooming so that Ms. Smith feels comfortable going out into the community to socialize

S – Specific – Ms. Smith needs helps because she is diagnosed with arthritis and states the pain stops her from doing those tasks herself
M – Measurable – once a day, 7 days a week
A – Attainable – with assistance from an HHA the participant should be able to meet this goal
R – Relevant – Ms. Smith will receive hands on assistance from her HHA, which is relevant to the role of an HHA
T – Time Bound – for the next year

SMART GOAL:
Ms. Smith is diagnosed with arthritis and reports to experience pain that prevents her from completing personal care (S). Ms. Smith will bathe, dress, and groom daily with hands-on assistance from HHA (R) with transferring into shower, washing body, drying off, getting dressed, and with brushing her teeth and hair once per day 7 days per week (M, A) for the next year (T).

PERS example: goal is to have assistance if they fall when their HHA or informal support are not home.
S – Specific – Ms. Smith has fallen 3 times in the past month when she was home alone
M – Measurable – Ms. Smith will wear her PERS unit when she is alone from 3p-8p every evening
A – Attainable – Ms. Smith can be wear a PERS unit at any time
R – Relevant – the purpose of a PERS unit is to call for assistance
T – Time Bound – for the next year

SMART GOAL:

Ms. Smith has a history of 3 falls in the month prior to the assessment and is diagnosed with arthritis and uses a walker for all mobility (S). Ms. Smith will wear her PERS from 3p-8p every day (M, A), after her HHA leaves and before her informal support returns home to be able to access emergency assistance (R) for the next year (T), should a fall take place.

Transportation example: goal is to go to the community/senior center more often to improve socialization

S – Specific – Ms. Smith is diagnosed with depression and reports having not left her house in months

M – Measurable – Ms. Smith would like to attend bingo at least once a week at the Senior Center

A – Attainable – Ms. Smith is mentally and physically capable of using public transportation

R – Relevant – Non-medical transportation is able to provide transportation to the Senior center

T – Time Bound – for the next 6 months

SMART GOAL:

Ms. Smith is diagnosed with depression and reports she has not left her home in the past few months which is making her feel worse (S). Ms. Smith will go to the Senior Center once per week(M, A), for the next 6 months(T), using the zone 2 Septa transpass(R).

SMART-goal-practice Download

You can practice building SMART goals with this:

- **Agree/Disagree-** If both the participant and the Service Coordinator agree on the goal then “Agree” is selected. If either the SC or the participant do not agree to some aspect of the goal then “disagree” should be selected.
- **Start Date**– Goals should be built upon from one PCSP to the next. If the participant has just chosen the goal to work on for the first time at the visit then “Start Date” would be the date of the visit. If the participant has been working on this goal from

prior PCSP's then the true start date of the goal should be obtained from the prior PCSP.

- **End Date**– The end date must always be current and should be based off of the "Time Bound" portion of the actual goal. If at the visit/assessment the participant states that they want to work on the goal for 6 months then the end date should be six months from the date of the visit.
    - There must always be a CURRENT goal, this means goals can not have an end date prior to the next visit, so discuss this with the participant when setting the end date.
- **Barriers** – Something that prevents the participant from achieving their goals. If a participant has no informal supports this needs to be documented in the barriers. Any cognitive issues must be addressed in the barriers.
    - Ex. Veronica is unable to cook without assistance due to pain in her back, preventing her from standing for longer than 5 minutes.
    - Ex. Dan forgets to charge and wear his PERS until when his HHA is not around.
    - Ex. John has no informal support to be able to assist him with bathing, dressing, and grooming.
    - Ex. Beth is low income and is unable to purchase diabetic appropriate foods to meet her medical needs.
    - Ex. Elizabeth has cognitive issues and is diagnosed with Dementia, she requires assistance with medication management
- **Intervention** – What can/will be done to overcome the barrier and proceed with achieving the goal. If a participant has informal support they need to be listed in the interventions with the specifics of what they will be assisting with.
    - Ex. Veronica's HHA will assist with meal prep in the morning and afternoon and will have HDM ready for Veronica to heat up for dinner when she is not around.
    - Ex. Dan's HHA will ensure the PERS unit is charging while they are there to supervise Dan's walks, and will remind him to wear the PERS unit when they leave for the weekend.
    - Ex. John's daughter/Jane will assist him with dressing and grooming before bed each night, Monday-Sunday.
    - Ex. Beth's son/David will do grocery shopping for heart healthy foods each Sunday