InterRAI Section A:

Goal Quick Guide

Purpose of a Goal

A goal represents the long-term impact that HCBS may have on a participant's overall safety, health, and well-being and goes beyond the immediate benefits of receiving services.

Goals may come from the participant or legal representative. In the rare circumstance when a participant cannot verbalize a goal, a primary unpaid caregiver may provide the goal for the participant. Case note documentation is required in these instances.

A goal should…

- Be something the participant hopes to accomplish, not a statement of their condition or fact.
- Focus on promoting safety, health, independence, well-being, and/or community integration for the participant with HCBS.
- Be participant specific. Assessors should not use identical goals for all participants.
- Include two parts: the **reason** for applying and **how** or **why** these services will help them.
- Have a stated outcome.
- Include any barriers that may prevent the goal from being met. If no barrier is identified, no documentation is needed.

Conversation Tips

- When asking questions about goals of care, keep your questions as general as possible
- Assessors shall summarize the participants responses into a goal statement and confirm the participant agrees with the stated goal.

Sample Questions

- Why are you applying for or receiving these services?
- How will these services help you?
- What changes are you hoping to see in your daily life?
- How do you see HCBS assisting with meeting any un-met needs of care?
- What are your goals for the participant's health and independence in the future?
- What HCBS services can assist the participant in remaining as independent as possible

Appropriate Goals	Inappropriate Goals
• "I would like assistance around the house to allow my broken leg to heal." • "My goal is to receive assistance with cooking as I am concerned with falling and burning myself" • "I want to be living on my own and retain my independence." • "My goal is to continue receiving services that will provide me support I cannot get through family to remain independent." • "I wish to remain in the RCF to ensure my medications are administered correctly." • "I would like to ensure I have consistent help available to help me with my day-to-day needs"	• "I need my broken leg to heal." *This is a statement and not a goal.* • "Due to leg and back pain, I am not able to stand up and cook." *This is a statement and not a goal.* • "I don't know or I'm really not sure." *There is no stated outcome.* • "I want to continue receiving services." *There is not a stated outcome.* • "RCF" or "ALF; "Remain in RCF." *There is not a stated outcome.* • "My grandson helps me a lot and I would like to get him paid." *This is not person/participant centered and does not include a stated outcome*

Example Barriers:

Goal: Continue receiving services to remain living independently in the home.

Barrier: The participant's provider agency has failed to consistently send an aide to the home, resulting in a gap of services. This would be considered a barrier to receiving services.

Goal: To have a hot meal prepared daily.

Barrier 1: Participant's oven/stove is broken, preventing hot meals from being cooked.

Barrier 2: The provider does not have an aide for the participant daily and only sends an aide 4 times a week.