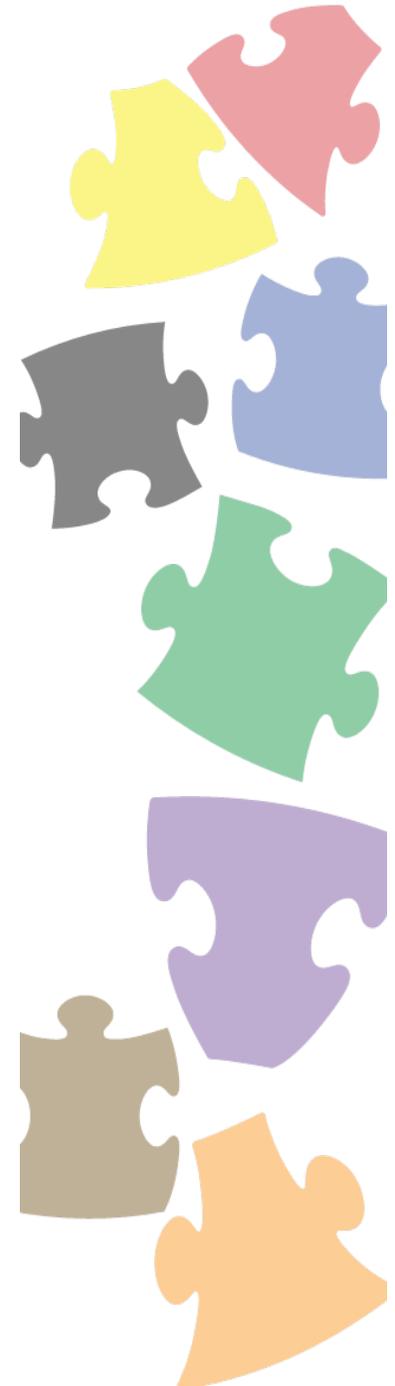
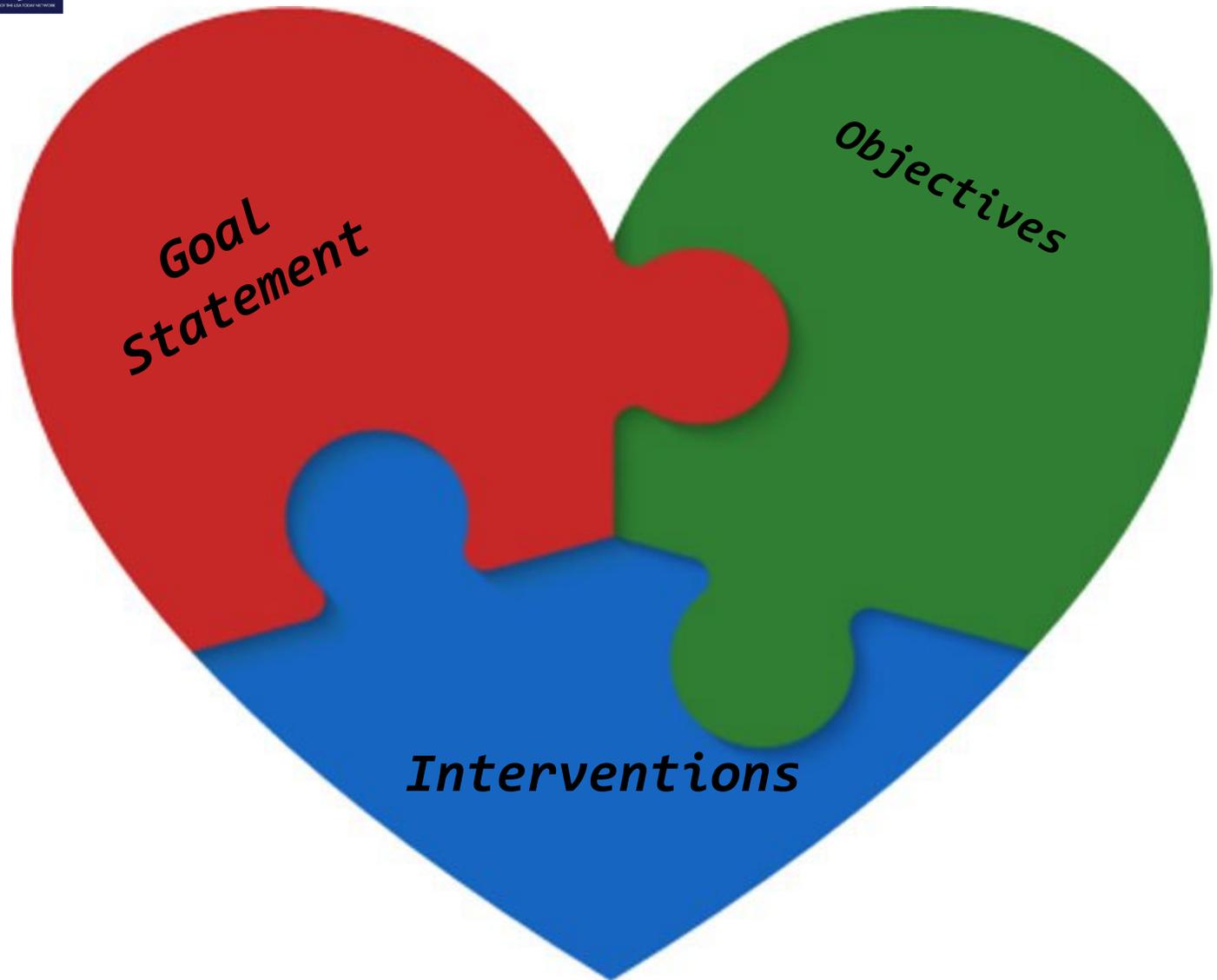




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Beverly Thompson  
Nicole Jones  
Chaudrika Baldwin  
Lucinda Brown  
March 2025



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# Housekeeping



Please keep your microphone on mute.



Please use the chat to for comments and questions.



As input is given, additional details may be added to the presentation. All materials used will be emailed to participants at the end of this week.





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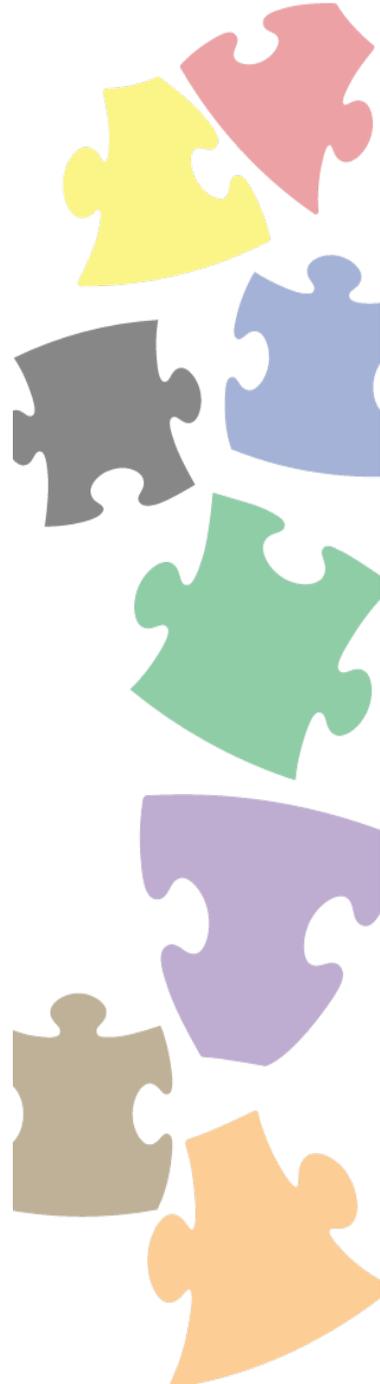


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## Simple Training Objectives

1. Define and understand the key components of a goal.
2. Write a good goal that meets the needs of the member and MDHHS' standards for those who self-direct services.





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Assessments are a good starting point for developing Goals

## Assessments

Identifies the skillset of an individual and can support a clinical need

Intake Assessment ~ Integrated Biopsychosocial ~ Residential Assessment ~  
Major Life Activity Assessment ~ Community Living Supports Tool  
~ Additional Respite Tool ~ Category of Care

## Medical Necessity

All services are based on medical necessity

**\*Medicaid is an insurance program and payor of last resort\***



# Medical Necessity – Golden Thread

The determination of a medically necessary support, service or treatment must be:

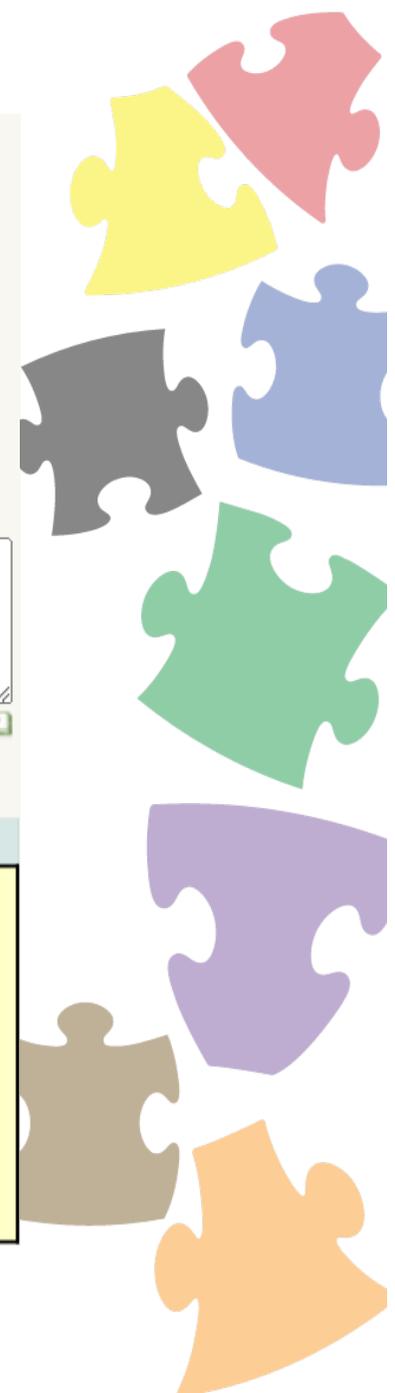
- Based on information provided by the person, and/or other people who know the person;
- Based on clinical information from health care professionals who have evaluated the person;
- Based on person centered planning;
- Made by appropriately trained professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the plan of service.

# What is Amount Scope Duration?

- **Amount:** The number of units (i.e., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided.
- **Duration:** The length of time (i.e., three weeks, six months) it is expected that a service identified in the individual plan of service or treatment plan will be provided.
- **Scope of Service:** The parameters within which the service will be provided, including:
  - Who (i.e., professional, paraprofessional, aide supervised by a professional);
  - How (i.e., face-to-face, telephone, taxi or bus, group or individual); and
  - Where (i.e., community setting, office, beneficiary's home); and
  - Frequency of Service(s) (i.e., daily, weekly, monthly, quarterly).



# Amount, Scope, & Duration



DURATION

SCOPE

**Provider**  
Personal Accounting Services-Site  
20500 Eureka Road, Suite 112  
Taylor, MI 48180-5343

**Consumer**  
00000012 Test Testee

**Individual Plan of Service**  
IPOS Eff: 03/04/2025 Exp: 3/3/2026

**Authorization Effective Date\***  
03/04/2025

**Authorization Expiration Date\***  
03/03/2026

**Urgency**  
 Non-Urgent (Standard) Pre-Service Request  Urgent Pre-Service Request

**Provider Notes**  
characters left: 30000

**Locus Level Of Care**  
Level 3A Community Based Svcs  Locus LOC Overridden

**Services** + Add Service

Service	Contract	Unit Type	Unit Rate
H2X15: Community Living Supports, Unlicensed, 15-minutes. - Bundled Authorization only code for H2015.	IDD Residential	15 Minutes	0.00

**Effective Dates**  
From: 3/4/2025 To: 03/03/2026

**Units per Period**  
From: [ ] To: 80

**Frequency**  
Per Week

**Total Units Authorized**  
From: [ ] To: 4,172 Calculate

**Where will the service be provided?**  
 Consumer's Residence  Community Setting  Agency Office(s)  Other: [ ]

**Related Goals** lookup  
1, 2, 3, 4

**Notes**  
[ ]

AMOUNT

# PLEASE TELL US SO WE WON'T HAVE TO ASK

**Provider**  
Personal Accounting Services-Site  
20500 Eureka Road, Suite 112  
Taylor, MI 48180-5343

**Consumer**  
0000012 Test Testee

**Individual Plan of Service**  
IPOS Eff: 03/04/2025 Exp: 3/3/2026

**Authorization Effective Date\***  
03/04/2025

**Authorization Expiration Date\***  
03/03/2026

[Use Current Date](#)

**Urgency**  
 Non-Urgent (Standard) Pre-Service Request
  Urgent Pre-Service Request

**Provider Notes**

Residential Assessment completed. Direct Hire will provide authorized supports. Member receives \$216 per month of Home Help that is provided by Direct Hire. Member is on the Hab Waiver. Member shares supports with 1 Housemate.

characters left: 30000

**Locus Level Of Care**  
Level 3A Community Based Svcs  Locus LOC Overridden

**Services** [+ Add Service](#)

Service	Contract	Unit Type	Unit Rate
H2X15: Community Living Supports, Unlicensed, 15-minutes.- Bundled Authorization only code for H2015.	IDD Residential	15 Minutes	0.00

**Effective Dates**  
From: 3/4/2025 To: 03/03/2026

**Units per Period**  
From: [ ] To: 80

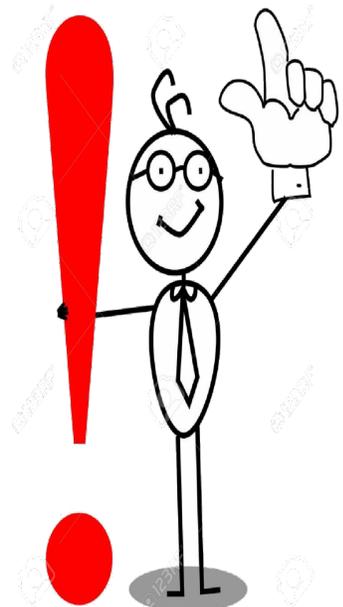
**Frequency**  
Per Week

**Total Units Authorized**  
From: [ ] To: 4,172 [Calculate](#)

**Where will the service be provided?**  
 Consumer's Residence
  Community Setting
  Agency Office(s)
  Other: [ ]

**Related Goals** [lookup](#)  
1, 2, 3, 4

**Notes**  
1Housemate/Direct Hire





# What are the main components of Goal?



- A. Interventions
- B. Goal Statement
- C. Objectives
- D. All of the above



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# What are the main components of Goal?



- A. Interventions
- B. Goal Statement
- C. Objectives
- D. All of the above

Correct Answer: D. All of the Above



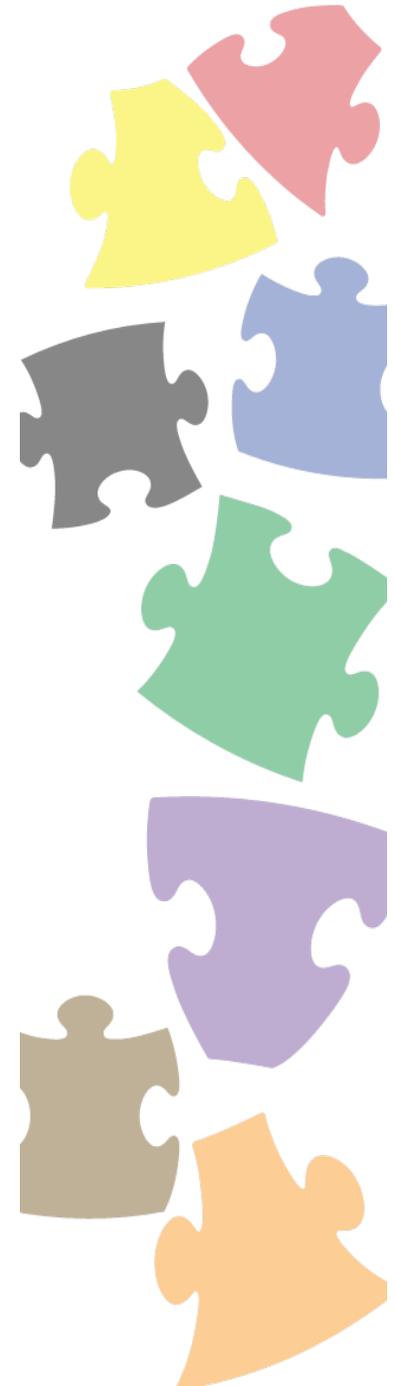


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1. Goal Statement- The Goal is the intended outcome/what the individual wants to achieve



- A. The Goal Statement must address what the person wants to achieve (**KEEP IT SIMPLE**).
- B. Each Goal Statement must be written in first person such as "I want" or Per the guardian who speaks on behalf of the person, he/she will...
- C. The Goal Statement must be clearly defined so that it is clear to determine what the person is aiming to accomplish.





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TOP  
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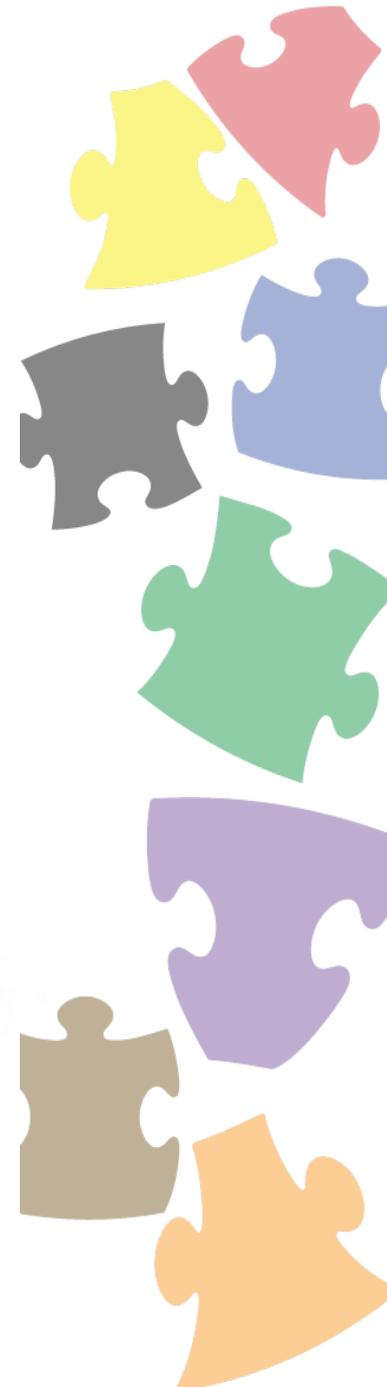
**Do Not** write Goals that contain clinical jargon that is not written in the individual's words.

**Do write** Goals that reflect the individual's words or the person who speaks on behalf of the individual's words (if the individual does not use words to communicate).



## Things to Consider

- The Goal should not be the service that is being requested such as therapy or an OT Evaluation.
- The Goal should address the intended outcome of the service being requested.
- A service may be an intervention for an individual to achieve a Goal or an outcome, but the service itself is not the Goal.
- The question to be answered is, what is the reason for requesting the services.



## Which Goals Below are Good Goals ?

1. Bill's mother stated, "We would like Bill to have a Behavior Treatment Plan to assist staff in dealing with Bill's self-injurious behaviors".
2. I want to go to camp this summer.
3. Jane requires support staff to continue to live in her current home and accompanied in the community due to her Moderate Intellectual disability, limited verbal skills, and health issues.
4. I want to be healthy.
5. Don's mother stated, "Don will attend EAI for vocational services".
6. Per mom, I would like Tammy to do things for herself.
7. I do not want to hit people when they make me mad.
8. Tim and his support circle expressed that he would like to hire an Independent Supports Coordinator. He would like to live his best life and use the Medicaid dollars available to him wisely.

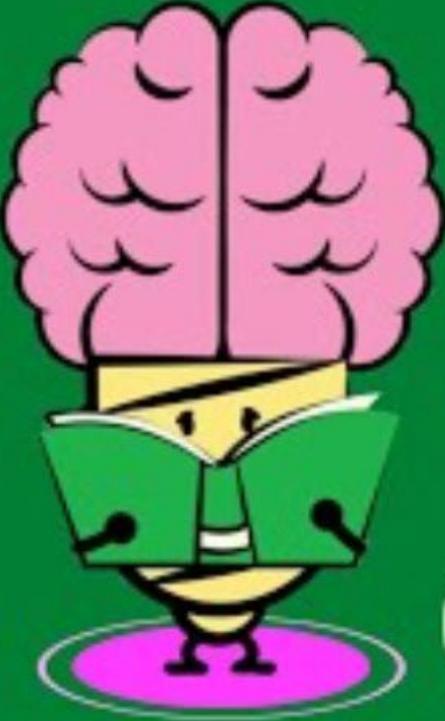




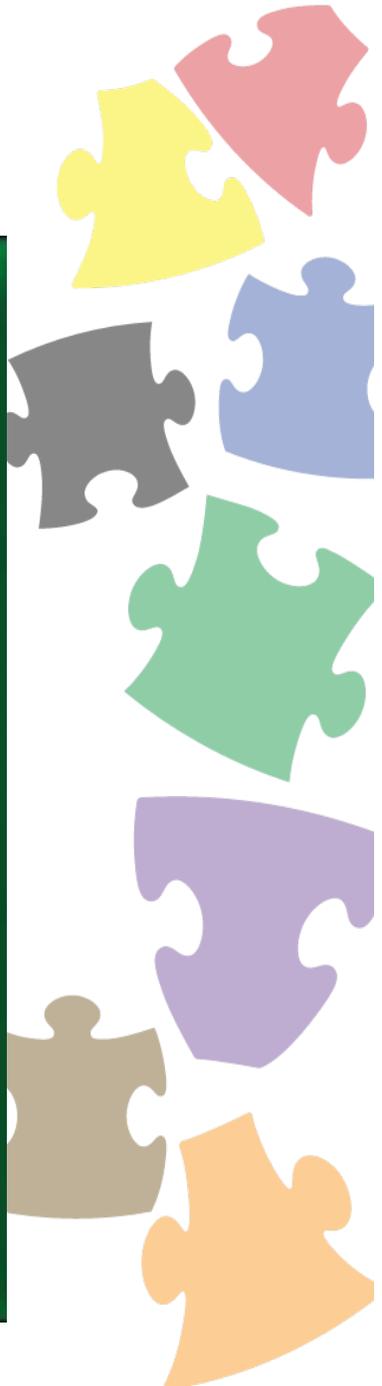
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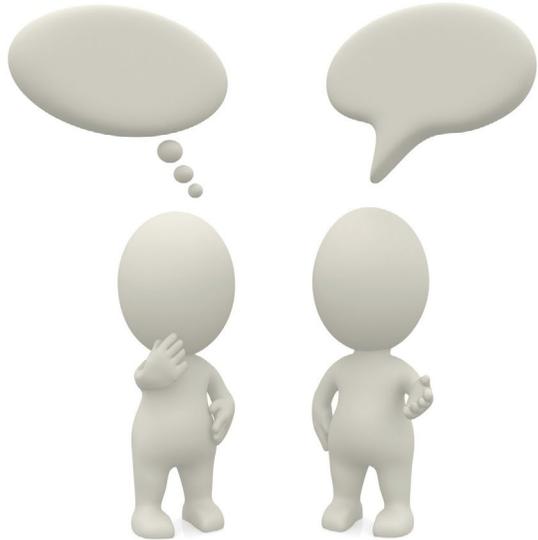


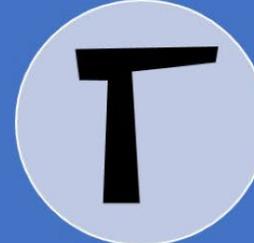
**SMART**  
GOALS  
George T. Doran

A green rectangular graphic with a dark green border. On the left side, there is a cartoon illustration of a pink brain with a face, wearing a yellow shirt and green pants, holding an open green book. To the right of the brain, the word "SMART" is written in large, colorful, stylized letters (S: purple, M: red, A: pink, R: orange, T: yellow). Below "SMART", the word "GOALS" is written in a simple, black, sans-serif font. At the bottom of the graphic, the name "George T. Doran" is written in a light green, sans-serif font.

# Objective

The **Objective** is the measurable part of the Goal Statement.



 <p><b>S</b></p> <p><b>Specific</b> Who, What, Where, When, Why, Which</p> <p>Define the goal as much as possible with no ambiguous language.</p> <p>WHO is involved, WHAT do I want to accomplish, WHERE will it be done, WHY am I doing this (reasons, purpose), WHICH constraints / requirements do I have?</p>	 <p><b>M</b></p> <p><b>Measurable</b> From and To</p> <p>Can you track the progress and measure the outcome?</p> <p>How much, how many, how will I know when my goal is accomplished?</p>	 <p><b>A</b></p> <p><b>Attainable</b> How</p> <p>Is the goal reasonable enough to be accomplished? How so?</p> <p>Make sure the goal is not out of reach or below standard performance.</p>	 <p><b>R</b></p> <p><b>Relevant</b> Worthwhile</p> <p>Is the goal worthwhile and will it meet your needs?</p> <p>Is each goal consistent with other goals you have established and fits with your immediate and long term plans?</p>	 <p><b>T</b></p> <p><b>Timely</b> When</p> <p>Your objective should include a time limit. "I will complete this step by month/day/year."</p> <p>It will establish a sense of urgency and prompt you to have better time management.</p>
---	---	--	---	--





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**TOP  
WORK  
PLACES**

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The following are verbs which are observable and measurable:

Advise  
Analyze  
Apply  
Appraise  
Arrange  
Assemble  
Assess  
Audit  
Calculate  
Categorize  
Change  
Choose  
Code  
Collect  
Combine  
Communicate  
Compare  
Compile  
Comply  
Compose  
Conclude  
Conduct  
Construct  
Contrast  
Convert  
Counsel  
Create  
Criticize  
Debate  
Deduct  
Defend  
Define  
Demonstrate  
Describe  
Design

Develop  
Devise  
Diagram  
Differentiate  
Discover  
Discriminate  
Discuss  
Distinguish  
Dramatize  
Edit  
Employ  
Enforce  
Estimate  
Evaluate  
Examine  
Experiment  
Explain  
Express  
Extend  
Formulate  
Gather  
Generalize  
Generate  
Identify  
Illustrate  
Incorporate  
Inspect  
Instruct  
Interpret  
Interview  
Inventory  
Investigate  
Judge  
Justify  
Label

List  
Locate  
Maintain  
Manage  
Manipulate  
Match  
Measure  
Modify  
Monitor  
Name  
Operate  
Organize  
Outline  
Paraphrase  
Perform  
Plan  
Point  
Practice  
Predict  
Prepare  
Produce  
Propose  
Question  
Rate  
Rearrange  
Recall  
Recommend  
Reconstruct  
Record  
Relate  
Repeat  
Report  
Reproduce  
Respond  
Restate

Retrieve  
Review  
Revise  
Rewrite  
Schedule  
Score  
Screen  
Select  
Separate  
Show  
Sketch  
Solve  
State  
Subdivide  
Summarize  
Support  
Tell  
Test  
Transcribe  
Translate  
Underline  
Use



# Interventions



- Includes step by step directions for staff to follow (written much like Job Description).
- Must be specific enough to allow an outside reviewer an understanding of how any service requested will be used.
- **Must detail where applicable *Flexibility will be used in services and supports*** regarding how the person wants to meet the Goals identified in the Individual Plan of Service. Beyond traditional services (*CLS or Respite*), people may decide to purchase classes, memberships, or specific items that will help with Goal Achievement. (Must be in the IPOS).
- Must identify which services will be ***Self-Directed***.
- Must be specific enough that all people responsible for any part of the goal to know what they should be doing.
  - \**Consider active and specific tasks such as : role-play, coaching, monitor, teaching, hand-over-hand assistance, modeling, prompting.*
- Indicate how often the Goal will be worked on, **Amount, Scope, and Duration**, (2 hours per week, 4 hours monthly, etc.) to give the member the best opportunity to succeed.
- Include how staff will document progress.
- Include the Supports Coordinator's role (linking, coordinating, monitoring, documenting progress).



## Interventions that mirror the Residential Assessment



### Interventions

A: John will utilize 40 hours/160 units of H2x15 per week for the following year.

John IS enrolled with ISPA and DOES have home help. John will utilize H2X15 in the following areas per the residential assessment completed on 3-24-25:

#### - Total Shopping:

o John loves shopping. His favorite places to go are Target, GameStop, 5 Below as well as stores in his neighborhood.

o John will utilize supports in this area 3 times per week for a total of 60 minutes.

#### - Money Management:

o Staff works on money management with John at when shopping at stores. He needs help with understanding the cost or value of items and then handling paying for it.

o John will utilize supports in this area 3 times weekly for a total of 15 minutes.

#### - Community / Socialization:

o John loves going shopping, out to eat, movies, and playing games. He likes to be out in the community daily, going for walks, playing basketball, going to the city pool and Dearborn Rec Center. His staff reports that he likes to be on the go all the time.

o John will utilize supports in this area for a total of 240 minutes daily.

#### - Attending Medical Appointments:

o John goes to the dentist every 6 months. He goes to his PCP as needed and for an annual physical. The time is adjusted since appts less than monthly is not an option.

o John will utilize support in this area once per month for 30 minutes.

#### - Health & Safety / Medical Complexity:

o John needs help with emergencies. He doesn't understand fully what an emergency is and how to respond. When in the community he will watch for traffic. He's limited in his ability to read and has difficulty with street signs. He doesn't know his address and is working on this. However he does know his parents' numbers. He is never alone in public.

o John will utilize supports in this area once per day for 60 minutes total.

#### - Symptoms/Stress Management Skills:

o John needs to have something to do at all times and gets stressed out if he is not doing things all day. He gets help with managing his stress in addition to getting out of the house and this takes additional time.

o John will utilize support in this area once per day for a total of 30 minutes.

John will utilize 8 units of T1017 targeted case management once per month for linking, monitoring, and coordination of services. ISC will monitor progress on this goal and document in monthly progress notes.

|

# LET'S ANALYZE THIS GOAL, OBJECTIVE, AND INTERVENTION

## Goal

1: Caregiver will assist/perform/provide me with: transportation for community inclusion, attendance at medical appointments, shopping, leisure choice and recreation activities, protection in the community, self-care skills, safety, social skills, so I can continue to live with my family which is the least restrictive environment through 03-28-25. ←

## Dates

Implementation  
03/18/2025

Target  
03/28/2025

## Status

Pending Signature

## Objective

### Objective Letter \*

A

### Objective \* ⓘ

My caregive will perform/assist me with ADL's such as feeding, dressing, bathing, and proper male grooming and meet my daily needs at least 2x per day.

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### Interventions ⓘ

Support Coordinator will submit authorization in the following codes for the monitoring monthly visit or as needed. H2X15 up to 50 hours per month.  
Caregiver and family will cooperate 100% of the time in the completion of all my health and safety.  
Support Coordinator will submit authorization for PAS in order to give them the rights to seek services.

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- Amount:** The number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided.
- Scope:** The parameters within which the service will be provided, including Who (e.g., professional, direct support professional/staff, aide supervised by a professional); How (e.g., face-to-face, group/shared with others or individual); and Where (e.g., community setting, office, beneficiary's home); and Frequency of Service(s) (e.g., daily, weekly, monthly, quarterly).
- Duration:** The length of time (e.g., three weeks, six months) it is expected that a service identified in the individual plan of service or treatment plan will be provided.)

### Services to Support the Goal - Amount, Scope, & Frequency \*

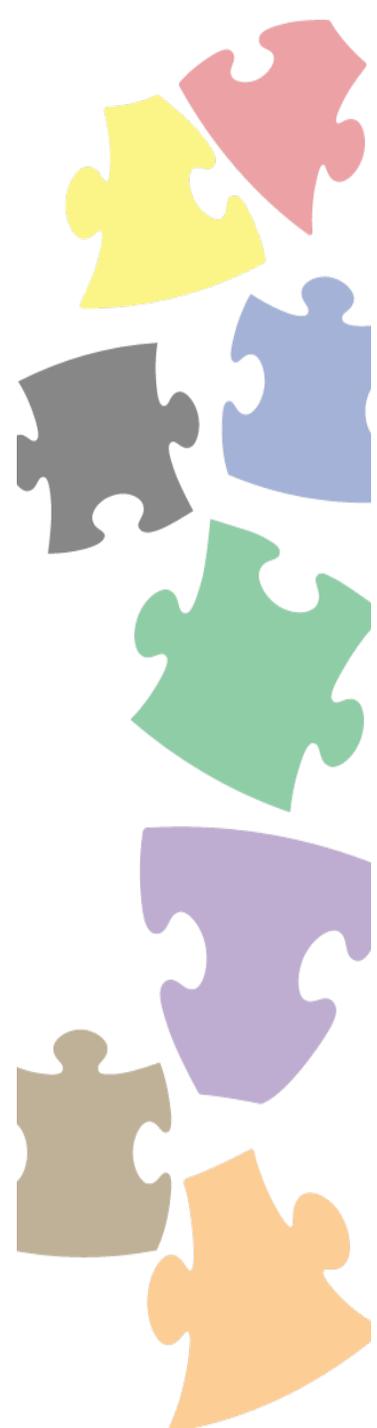
50 hours/200 units have been authorized to implement the Goals in this individual's IPOS.



## Goal Statement, Objective, and Intervention Checklist

Please read what you wrote and confidently be able to verify these areas are addressed. A member's GOAL or Desired Outcome includes; Goal Statement, Objective, and Interventions

- The **Goal Statement** is in the person's own words.
- The **Goal Statement** identifies what the member wants to achieve or what is the intended outcome. The statement must be in first-person language (ex. I will...) or with identifying legal rep speaking on behalf of the person.
- The **Objective** is S.M.A.R.T. Specific, Measurable, Attainable, Relevant, Time-Bound.
- Every **Objective** should be short, simple, and to the point. It will answer the question, how will any one reading the plan know if the goal is achieved?
- The **Intervention** can detail what the person can currently do (baseline/their contribution)/why this is important.
- The **Intervention** identifies what community or natural supports have been exhausted before CMH services requested.
- The **Intervention** identifies what support is needed to help achieve the outcome/goal. Use phrase such as, "budget flexibility will be used for \_\_\_."
- The **Intervention** must identify what services the person will self-direct with a statement such as, "X will self-direct his community living supports. However, other supports may be used in lieu of this service to accomplish the goals in the IPOS as long as the total budget is not exceeded".
- The **Intervention** identifies how often (hours, # of times per week/month) the person needs help/the service to have the best opportunity to achieve goals; the amount, scope, and duration of services (ie. authorization). This total should be reasonable to accomplish the intended outcome.
- The **Intervention** identifies the number (can be a range) of members the service(s) is shared with. This must be included in all applicable interventions.
- The **Intervention** is detailed enough to be a "job description" or details the steps to give the person the best opportunity to learn/achieve their goal.
- The **Intervention** identifies how staff will document progress.
- The **Intervention** identifies the SC will review/document progress on goals. v4 updated

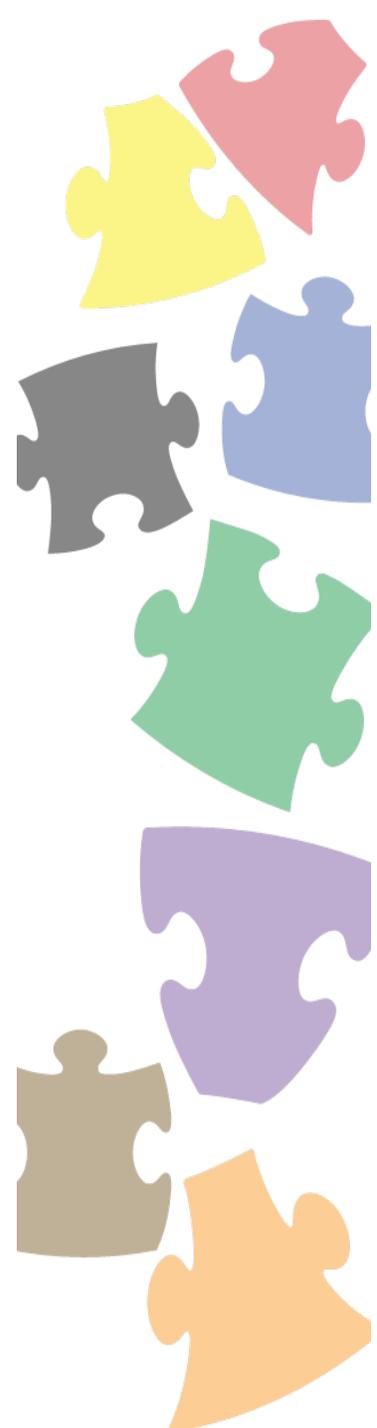




4 Per Sally's mother, "I would like Sally to be safe around water".	Implementation 03/25/2025	Target 09/25/2025	Pending Signature	<a href="#">Change</a> <a href="#">View</a> <a href="#">Delete</a> <a href="#">Print</a>
<b>Objective</b>	<b>Dates</b>		<a href="#">Add Objective</a>	
A Sally will learn 2 techniques to keep herself safe in the water.	Implementation 03/04/2025	Target 03/03/2026	<a href="#">Change</a> <a href="#">View</a> <a href="#">Delete</a>	
<p><b>Interventions</b></p> <p>Sally currently <b>self-directs</b> her 6 hours of community living supports.</p> <p>Sally is unable to swim but any opportunity she gets, she will dart toward the water. Staff must remain at arms length anytime she is around water. The circle discussed the benefits of Sally taking swimming lessons.</p> <p>Sally will <b>use her individual budget in a flexible manner</b> to purchase a membership at YMCA and swimming lessons. The membership would also allow ongoing access to a pool and other fitness activities once she has mastered her water safety goals.</p> <p>Support staff or natural supports will remain with Sally at all times.</p> <p>Support staff will document progress for services provided.</p> <p>The Support Coordinator will link, coordinate, and monitor services. The Support Coordinator will review staff's written documentation and summarize in progress notes.</p> <p><b>Services to Support the Goal - Amount, Scope &amp; Frequency</b></p> <p>Amount: 6 hours/24 units of community living supports</p> <p>Scope: Support staff (who), face to face (how), in-home and in the community (where) every week (frequency)</p> <p>Duration: 3 months</p> <p>Amount: 1 hour/4 units of Target Casemanagement</p> <p>Scope: Support Coordination (who), face to face (how), in-home and in the community (where) every week (frequency)</p> <p>Duration: 12 months</p>				



How is Sally using her individual budget for her goal to be safe around water?



**Index**

- 1. **Basic Info**
- 2. [Self-Directed Services](#)
- 3. [Total Supports](#)
- 4. [Signatures](#)

**1. Budget Worksheet: Basic Info**

Budget Date\*        Expiration Date\*    
364 Days (from today.)

PCP\*         Staffing Agent       Direct Hire

Fiscal Intermediary [lookup](#) [clear](#)

Address

City       State       Zip

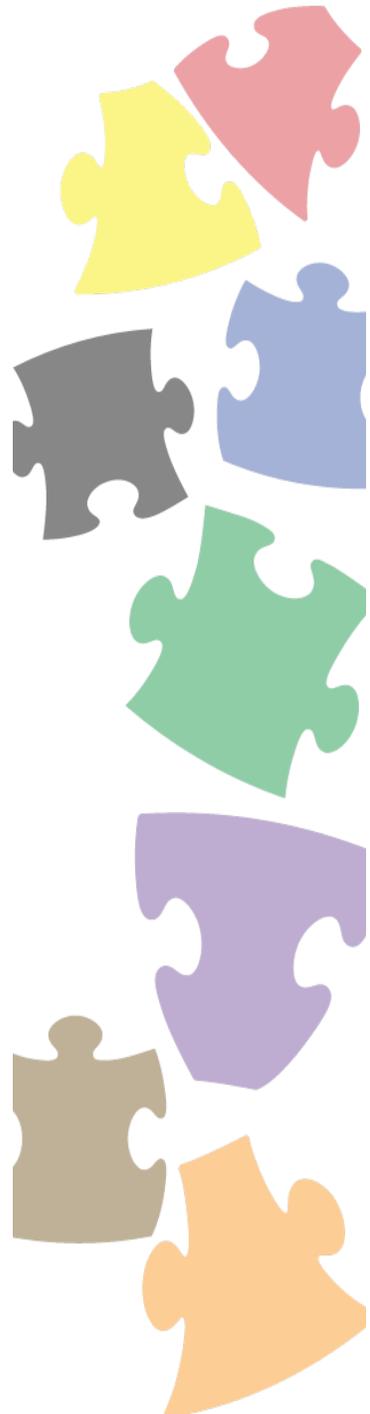
Home Help must be applied through MDHHS (provides personal care services to individuals who need hands-on assistance with Activities of Daily Living)

	Monthly (\$)	Annually (\$)
Home Help Amount	<input type="text" value="343.00"/>	4116.00

**Narrative**

Budget flexibility will be used for:  
 Membership  
 Swimming lesson

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# Frequently used Categories

- 
- Health club/Organization memberships
  - Skill Development Classes
  - Staff Development
  - Equipment less than \$240
  - \*Employer Related Expenses (office supplies, advertisements)
  - \*Local Community Engagement (Activities)
  - \*Employee costs (mileage, incentives, wages)

\*Categories which are automatic for people who have direct hires



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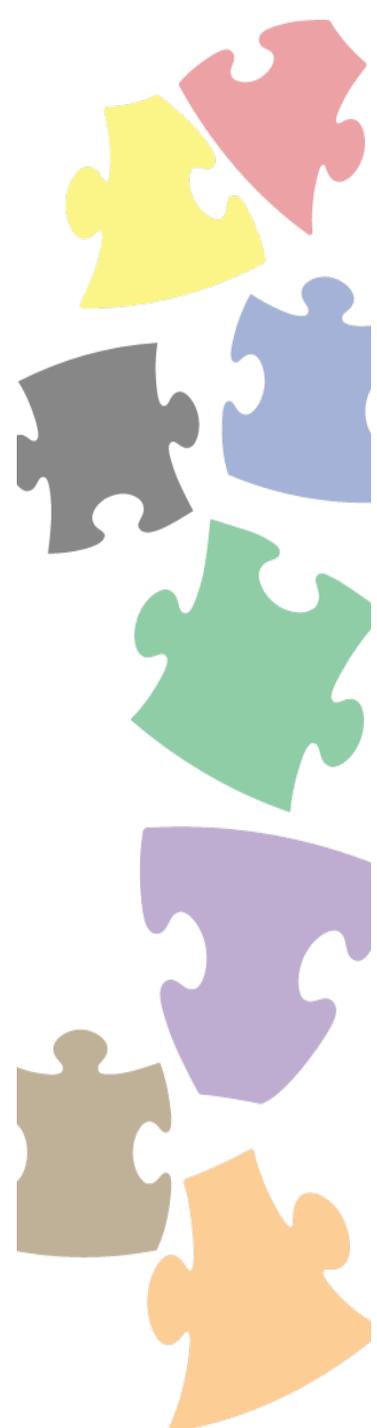


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Use these words;

"\_\_\_\_ (name)  
Self-Directs (name  
the service)" and  
"\*Budget Flexibility  
will be used  
for....."

\*When applicable





- IPOS, Addendum, and Periodic Reviews **must be signed**

-Budgets **must be signed**

These two documents give the FMS permission to use Medicaid funds to pay for supports and services. **If the documents are not signed, dollars can be recouped during a Medicaid audit.**

## In-Service and Training



- ❑ The Support Coordinator (SC) must in-service the IPOS (Goals, Objectives, and Interventions).
- ❑ Case Holder (SC) must train the Employer of Record on the IPOS before the Employer can train others.
- ❑ Staff must document progress on the Goal.
- ❑ SC must review written progress on goals to demonstrate services are being used and meeting the needs of the member.

If an individual is not making progress or achieves the goal, **Re-Group, Re-Think, and Re-Write** the Goal.





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Goals are necessary to help individuals to lead productive, inclusive lives. Good goals meet the needs of the individuals receiving services and the auditors requirements.

Goals must be developed for authorized services and all requested services must be based on medical necessity.

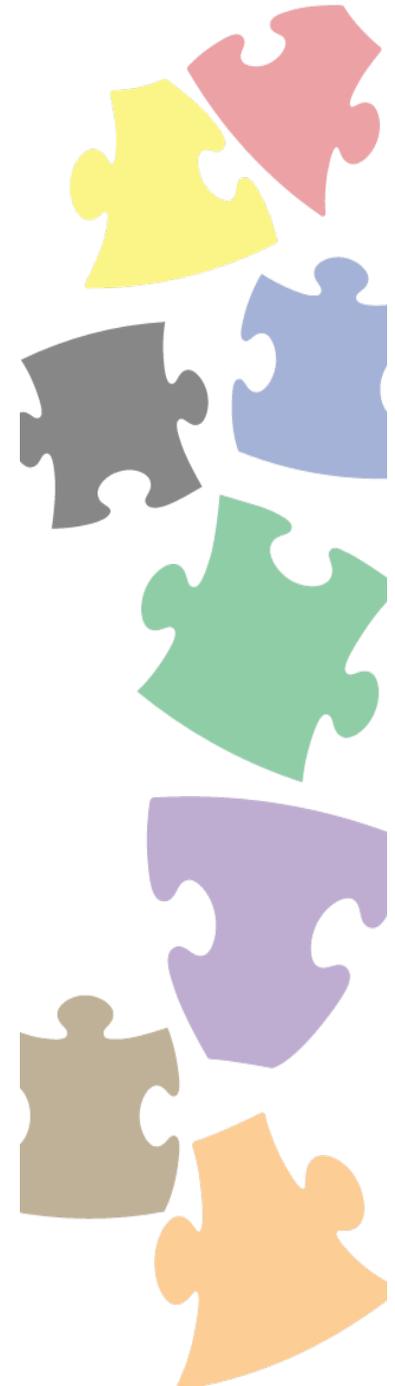
The amount, scope, and duration must be clearly identified in every goal.

Writing concise and detailed goals increases the likelihood that an individual will successfully achieve his or her goal.

Goals provide a good Job Description for staff to help the individuals to meet their desired outcomes.

Goals meets the requirements as listed in the Mental Health Code Section 330.1712: " A treatment plan shall establish meaningful and measurable goals with the recipient".

Goals are not about services, but they are about creating great lives.





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