Goal Setting & Discharge Planning

SETTING GOALS AND PREPARING FAMILIES FOR SUCCESS.

IFSTAN Webinar
12/13/2019
11:00 am

Next Webinar
01/20/2020
11:00 am

Goal Setting 101

Research shows that if we write things down we are more likely to accomplish them.

This can serve as a reminder as to what we're working toward.

Goals are not absolute; there is always room for changes and modifications.

Done with, not for families: family/participant lead the goals.

Part of our work, our program, our model of service delivery.

Model specific tools and guides to assist with the process.

GOALS: Why & How

Why do we set goals?	How do we set goals?
Assisting families on their path to self sufficiency will always include a goal setting process. This gives the family an opportunity to think about what they want and where they want their life to go. Setting goals allows the family to feel empowered and to gain a greater sense of self-worth.	Make it a conversation. Ask open ended questions. Have the family brainstorm out loud or on paper.

The Art of Goal Setting

Have a natural conversation full of open ended questions. Not only can this get the family to open up about goals but you might learn a few NEW things about them along the way!

Encourage the family to be creative, let them play with ideas that are both realistic and completely insane! This will relax the family and make the process of setting specifics seem less daunting.

Standard 4: Service Planning & Monitoring

Families and providers work together to develop and review service plans that are the basis for delivery of appropriate services and support.

NA The organization provides only parent education groups or short term in-home family support services.

4.01
A family-centered service plan is developed within an appropriate timeframe with the full participation of family members as appropriate, and expedited service planning is available when crisis or urgent need is identified.

Interpretation: Service planning is to be conducted so that family members retain as much personal responsibility and self-determination as possible and desired. Individuals with limited ability in making independent choices can receive help with making or learning to make decisions.

What does this mean?

Breakdown: 4.01

4.01 intends for programs to utilize their policy *IN* practice. Your program has the freedom to set the "appropriate timeframe" however, this timeframe needs to be found to follow your policy AND to be documented as such.

4.01 requires "full participation of family members as appropriate". This means that the participant and whomever the participant chooses *LEAD* the goal setting process.

4.01 stipulates that "expedited service planning is available when crisis or urgent need is identified". Should a participant experience a crisis situation or a need that requires immediate attention this should be addressed before all else. These needs would supersede other goals but not altogether eliminate them unless the participant wishes to do so.

Standard 4: Service Planning & Monitoring

4.02

The service plan is based on the assessment, is tailored to the family's unique needs and priorities, is measurable, and includes:

a) agreed-upon goals, desired outcomes, and timeframes for achieving them;
b) services and supports to be provided that build on the families strengths and addresses the family's risks, and by whom;
c) includes a parent's or legal guardian's signature;
d) provider and family's regular review of progress toward achievement of goals and;
e) signed revisions to service goals and plans.

Interpretation: A family's unique background, experiences, skills, race, culture, ethnicity, language, religion, and socioeconomic status are to be taken into consideration when developing a service plan. Providers should be fully informed about issues and preferences that may impact service delivery with various groups in the service population.

What does this mean?

Breakdown: 4.02

4.02 intends that service planning "is tailored to the family's unique needs and priorities". This means that each individual participant's goal form should reflect their "assessments", strengths, and needs.

4.02 requires measurability. This should be reflected within a goal plan as well as within documentation.

4.02 stipulates that service plans include five specific bullet points found within the standard.

Standard 4: Service Planning & Monitoring

4.03
The provider and a supervisor, or peer team, review the case quarterly to assess:

a) service plan implementation;
b) the family's progress toward achieving goals and desired outcomes; and
c) the continuing appropriateness of the family's goals.

Interpretation: Experienced providers may conduct reviews of their own cases. In such cases, the provider's supervisor reviews a sample of the provider's evaluations as per the requirements of the standard. Timeframes for service plan review should be adjusted depending upon issues and needs of persons receiving services, and the frequency and intensity of services provided.

What does this mean?

Breakdown: 4.03

4.03 intends for service plans to be reviewed “quarterly”. This should be reflected within supervisory documentation.

4.03 requires that the family support worker and the supervisor discuss the “family’s progress toward achieving goals and desired outcomes”. Again, this should be reflected within supervisory documentation.

4.03 stipulates that the “appropriateness of the family’s goals” is continually reviewed in order to guide and ensure that the family support worker is providing the most suitable services.

Goal Setting Tools

What tools do you as a program need to be successful?

Your program likely has a family support goal planning document.

This document is designed to help *guide* the goal setting process.

-Write on it

-Scribble on it

-Make changes

-Scratch out mistakes

After all this is a process!

Provide families with their own copy to do the same. Once goals are nailed down complete a final goal planning document with appropriate dates and signatures.

Remember, the most important tool you'll have is the **FAMILY!**

Sample Planning Forms

Family Name:_____

Parent Signature:_____ Date:_____

Parent Educator Signature:_____ Date:_____

Family Goal And Desired Outcome	Established By:	Expected Completion	Steps and Recommended Resources	Who will do this? PE (or) Family	Done	Check In: Do I still want to focus on this? Date	Yes/No
	☐ Family ☐ PAT	Date:			☐		
		☐ Fully Met ☐ Partially Met ☐ Not met			☐		
					☐		
					☐		
					☐		
					☐		
					☐		
					☐		
	☐ Family ☐ PAT	Date:			☐		
		☐ Fully Met ☐ Partially Met ☐ Not met			☐		
					☐		
					☐		
					☐		
					☐		
					☐		
					☐		

Sample Planning Forms

Our Family Development Plan

Date:_____

Outcome Area: (*check all that apply*): **Parent-Child Interaction ( ) Development-Centered Parenting ( ) Family Well-Being ( )**

Our Goal:_____

This goal will bring the following change(s) for our family:_____

_____

_____

Our anticipated goal completion date:_____

Action Steps:

WHAT will be done:	WHO will do it:	By WHEN:	Date Completed	Progress Update

Comments:_____

_____

_____

Family Signature:_____ **Parent Educator Signature:**_____

Sample Planning Forms

Wellness/Goal Planning

Participant Name: _____ Enrollment Date: _____

Family Strengths: _____

Support System Identified by Participant: _____

Goals Set by: _____

WHAT (goal)	WHEN (time-frame)	HOW (resources)	WHO (support)
1)			
2)			
3)			

Goals Are S.M.A.R.T: Specific ☐ Measureable ☐ Achievable ☐ Realistic ☐ Timely ☐

Check-in: Weekly ☐ Bi-Weekly ☐ Monthly ☐ Quarterly

What will things looks like when services end? _____

_____

Participant Responsibilities: _____

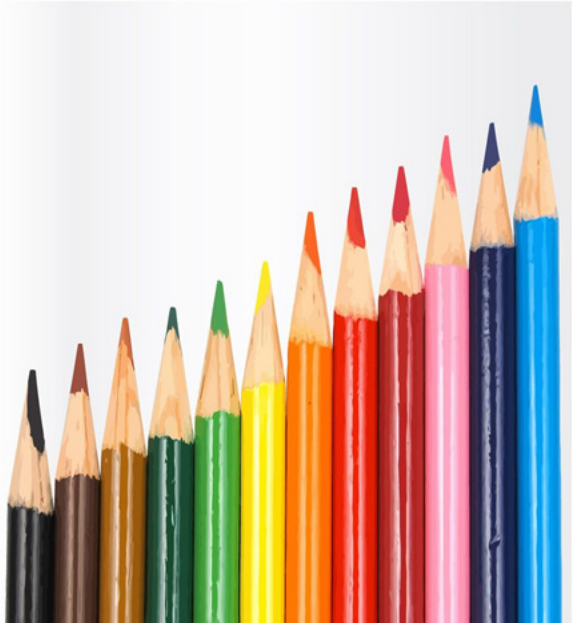
FUP Worker Responsibilities: _____

Family-Centered Adjustments: _____

_____

Participant Signature & Date: _____

Staff & Supervisor Signature & Date: _____



Case Closing versus Aftercare

Case Closing: the process in which the program, the participant, and others as applicable work together to transition the family out of a program's services. This process can happen when a family completes the program or decides to end services prior to completion.

Aftercare: the process in which the program, the participant, and others as applicable work together to ensure that the family can continue to access appropriate resources when services are completed or when services are ended.

Standard 13: Case Closing & Aftercare

Case closing is a planned, orderly process, and the organization helps the family develop a plan for obtaining follow-up services.

NA The organization provides only parent education groups or short term in-home family support services.

13.01
Planning for case closing:
a) is a clearly defined process that includes assignment of staff responsibility;
b) begins at intake; and
c) involves the provider, family members, and others, as appropriate.

What does this mean?

Breakdown: 13.01

13.01 intends for the process of case closing to be clearly documented with defined responsibilities assigned to staff.

13.01 requires that case closure begins at intake. This can be done in various ways via intake forms, initial assessments, etc…

13.01 stipulates that case closure is to include the worker, participant, and other representatives as applicable.

Standard 13: Case Closing & Aftercare

13.02
Upon case closing, the organization notifies any collaborating service providers, including the courts, as appropriate.

What does this mean?

Breakdown: 13.02

13.02 intends to ensure that “any collaborating service providers” are notified that home visitation services are closing.

13.02 requires that should the participant be involved with the courts, that the courts are notified that the home visitation services are closing.

13.02 stipulates that these provisions are taken in order to maintain case file integrity, best practices for service delivery, and fulfillment of program model expectations.

Standard 13: Case Closing & Aftercare

13.03
If a family leaves the program for whatever reason, the organization makes every effort to link family members with appropriate services.

What does this mean?

Breakdown: 13.03

13.03 intends to ensure that all participants receive aftercare services no matter the manner of program services ending.

13.03 requires that participants receive necessary resources from collaborating agencies once program services have ended.

13.03 stipulates that these provisions are taken in order to maintain case file integrity, best practices for service delivery, and fulfillment of program model expectations.

Standard 13: Case Closing & Aftercare

13.04
Families and providers work together to develop aftercare plans that:

a) are developed sufficiently in advance of case closing to ensure an orderly transition;
b) identify services needed or desired by family members; and
c) specify steps for obtaining these services.

Interpretation: While the decision to develop an aftercare plan should be based on the wishes of the family, unless aftercare is mandated, the organization is expected to be strongly proactive with respect to aftercare planning. To increase the likelihood that needed supports and services will be accessed after case closing, the organization should take the initiative to explore suitable resources, contact service providers, and follow up on the aftercare plan, as appropriate, when possible, and with the permission of the family.

Research Note: Due to funding constraints, programs providing early intervention under Part C of IDEA can generally only serve children under age three. Accordingly, literature emphasizes the importance of helping children and families enrolled in these programs facilitate a smooth, successful transition into child care, school, or an alternate intervention program.

What does this mean?

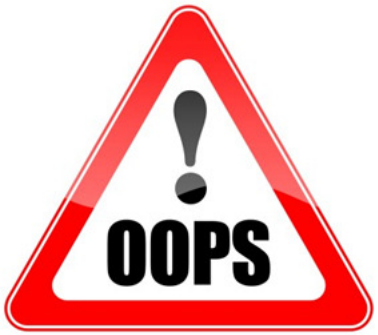
Breakdown: 13.04

13.04 intends for the program, along with the participant, develop an appropriate aftercare plan that includes “needed or desired” continued care resources.

13.04 requires that aftercare plans “are developed sufficiently in advance” in order for aftercare services to be contacted and/or accessed “to ensure an orderly transition”.

13.04 stipulates that the aftercare plan “specify steps for obtaining these services”. These specific steps are to be be documented within the participant case file.

When Planning Cannot Be Planned



It is understood that not all families choose to continue services to the end of delivery. Some participants may tell their worker they want to end services while others simply end all forms of contact.

DOCUMENTATION is key in that case files must show that "*all attempts were made to notify any collaborating service providers, including the courts, as appropriate*" AND "*the organization makes every effort to link family members with appropriate services*", as the standard states.

When Do Case Closing & Aftercare Start?

At Intake!

Make it a conversation.

Continue the discussion throughout service delivery.

Have documentation show this for practice/evidence.

How to Address Case Closing & Aftercare

What will things look like when services end?

How can you utilize your strengths when home visits end?

Tell me about goal planning once [target child] graduates the program?

Which resources will you continue to utilize once program services are over?

Let's talk about some resources we've used or discussed that you think you will continue to use once visits with me end.

Contact Us

IFSTAN Coordinator

Risa Ergenbright
risa.ergenbright@lsiowa.org

Program Specialist

Leighann Mitchum
leighann.mitchum@lsiowa.org

Questions?