Measureable Goals and Outcomes

SMART Goals
SMART Goals

• **Specific** – Specifically define the goal for the member using action verbs—what member will do or maintain, and how. What *exactly* do you want the member to achieve?

• **Measurable** – Identify how the member’s success will be measured concretely—how will we know if they met the goals or not?

• **Attainable** – Make sure the goal is realistic and possible for the member to reach.

• **Relevant** – The goal should be relevant to the member and reflect member wants and/or needs.

• **Time Bound** – Establish and STATE a realistic time frame for achieving the goal—give an actual date or month/year.
Member Centric Language

- Write goals in first person language
  - “I will...”
  - “My needs...”

- It is important to balance the need for member centered language and SMART goals as both are required components to goal writing.
Example - Typical Goal - ADL Independent

<table>
<thead>
<tr>
<th>Goal Category</th>
<th>Member Goal</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>IADLs/ADLs</td>
<td>I will become more independent in walking</td>
<td></td>
</tr>
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</table>
### Improved Goal- ADL Independence

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<td>IADLs/ADLs</td>
<td>(A/R) I will become more independent in walking as demonstrated by my (S) (M) ability to walk with my cane or walker within the next 3-6 months. (T/A)</td>
<td>I will continue to work with Physical Therapy 2 days a week to strengthen my legs and increase my ability to ambulate safely.</td>
</tr>
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<tr>
<td>-----------------------</td>
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</tr>
<tr>
<td>Pain Management</td>
<td>I will not have pain.</td>
<td>Take measures to control pain.</td>
</tr>
</tbody>
</table>
Goal Example

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<tr>
<td>Pain Management</td>
<td>My pain will be (A/R) controlled as evidenced by my report, (T) at my next assessment, of (S/M) a pain rating of less than ##, on the 0-10 pain scale rating.</td>
<td>I will schedule a clinic appointment to discuss pain management. (Is this Time Bound?) (How could it be improved?)</td>
</tr>
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<tr>
<td>Falls Risk</td>
<td>I will (R/A )reduce my falls risk by (S)using my walker (T) (M) each time I ambulate greater than (M) ## feet and report (M) no falls in a (T) 6 month time span.</td>
<td>I will utilize adaptive equipment consistently and notify CM or Primary Care Provider if service or equipment not meeting needs. I will accept services in my home (homemaking, PT/OT home safety eval, lifeline) to secure my safety. My Care Manager reviewed environmental concerns r/t falls risk with me (i.e. scatter rugs, keeping walkways clear, etc.) My Care Manager will order a falls prevention kit.</td>
</tr>
</tbody>
</table>
# Example – Smoking Cessation

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<tr>
<th>Member Goals</th>
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<th>Target Date</th>
<th>Monitoring Progress/Goal Revision Date</th>
<th>Date Goal Achieved /Not Achieved (Month/Year)</th>
</tr>
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<tr>
<td>I will be smoke free as evidenced by not having any cigarettes.</td>
<td>-Schedule appointment with PCP to discuss smoking cessation aides &lt;br&gt;-CC will provide information regarding Health Plan’s quit line &lt;br&gt;-Take OTC products or medication as prescribed by PCP</td>
<td>3/2018</td>
<td>9/20/2017 – Has talked with PCP about smoking cessation. No OTC products or prescriptions used at this point. Member developed plan with quit plan representative. Has cut down to 5 cigarettes/day.</td>
<td>3/15/2018-Reviewed goal. Goal met. Member has been smoke free since 1/1/2018. Will modify goal on next care plan to remain smoke free.</td>
</tr>
</tbody>
</table>
### Member Goals

| My PTSD signs/symptoms will be under control as evidenced by sleeping at least 4-6 hours per night. (S, M, A, R) **Time bound is not specified.** |

### Intervention

- Member will take sleep aide medication as prescribed
  - CC will provide information about MH supports and refer as needed
  - Member will contact MD if signs/symptoms worsen for possible medication adjustment

### Target Date

3/2018

### Monitoring Progress/Goal Revision Date

9/20/2017

Reviewed with member at 6 month check-in. Member reports she has been sleeping well at night (at least 4 hours each night). Goal met, member would like to continue. See goal on new Care Plan.

### Date Goal Achieved/Not Achieved (Month/Year)

Reviewed 3/15/18-Member stated she has been sleeping well at night (at least 4 hours each night). Goal met, member would like to continue. See goal on new Care Plan.
### Example - Health Condition Goal

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</table>
| I will manage my CHF as evidenced by (S) (M) gaining less than 2 lbs/week for (A,R) next six months. (T) | - Follow cardiac diet  
- Member will take cardiac meds daily  
- Daily weigh-ins and contact MD if greater than 3-5 lb. wt. gain/week  
- Health coaching referral | 9/2018 | 3/15/2018  
Member states she follows cardiac diet, no calls needed to MD for weight gain. |
# SMART vs. Non-SMART Goals

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<tr>
<th>Not SMART Goal</th>
<th>SMART Goal</th>
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<tbody>
<tr>
<td>I want to lose weight (not specific)</td>
<td>I want to lose 15 pounds (S,M) (A,R) within the next 6 months (T)</td>
</tr>
<tr>
<td>I want help with my diabetes (not specific, not measurable)</td>
<td>My blood sugars will remain stable (between x-x range (S,M) (A,R) over the next 12 months (T)</td>
</tr>
<tr>
<td>I will stay living in my home (not specific)</td>
<td>1. I will take my BP medication as directed every day for the next 6 months.</td>
</tr>
<tr>
<td></td>
<td>2. I will be free from falls for the next year.</td>
</tr>
<tr>
<td></td>
<td>3. I will eat a minimum of 1 healthy meal/day.</td>
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## What Not to Do - Intervention as a Goal

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<td>Get a shower bench.</td>
<td>Care coordinator will contact Durable Medical Equipment supplier to obtain shower bench.</td>
<td>1/8/18</td>
<td>Bench was obtained</td>
<td>1/8/18</td>
</tr>
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</table>
## Example – Corrected Version

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</table>
| I will remain free of falls while showering (S, M, A, R) for next six months. (T) | -- CC will order shower bench from DME supplier  
--Member will shower while homemaker is present for safety  
--Member will complete strengthening exercises | 12/2018     | 3/13/2018-Shower bench obtained. Member is utilizing when taking a shower. Member is showering when homemaker is present. Exercises not started. | 3/13/2018 |
Common Errors in Goal Writing

• Interventions named as goals.
• Date intervention will be completed listed as target date.
• Using date care plan was written as the target date.
• Not having at least one active goal that continues until the next assessment.
• Putting dates that haven’t happened yet in the monitoring progress or date achieved column.
Put Goals to the SMART Test

• Review goals at each assessment/review.
• Do they fit the SMART format?
• Make changes as needed.
• Outcomes should answer the question – was the goal met? What was the outcome of the specific, measurable goal? Was it met or not?
  • Use “as evidenced by/as demonstrated by” in writing specific and measurable goals.
Where to Find Goal Ideas - CCP

• Advanced directives.
  – Does member need an advance directive?

• Health prevention/chronic conditions
  – Pain screening.
  – Medication compliance.
  – Frequent visits to ER.
Where to Find Goal Ideas - LTCC

• **Best practice recommendation**: document additional information in comment sections on LTCC to use in goal writing.

• Caregiver supports/social resources.

• Health assessment
  – Multiple diagnoses.
  – Medication management.

• Medical utilization – frequent visits to physician/clinic.
SMART goal writing model

- SMART: **S**pecific, **M**easurable, **A**ttainable, **R**elevant, **T**ime-Bound. (Identify each letter in the goal)

Suggestions for where to find information for goal writing

- Member input
- LTCC
- Collaborative Care Plan.

Be careful not to write interventions instead of goals.

Use “as demonstrated/evidenced by” to bring goals to a specific level.
Questions?
Clinical Liaisons

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