SMART GOAL EXAMPLE GUIDE

A TOOL FOR MEDICA CARE COORDINATORS

WHAT IS A SMART GOAL?

Specific	What exactly needs to be accomplished? Why do we want to accomplish this goal?
Measurable	How will we know we have succeeded? How much change needs to occur? How many actions or cycles will it take?
Attainable	Do we have the resources to achieve this goal? Is the goal a reasonable stretch? Is the goal likely to bring success?
Relevant	Is it a worthwhile goal? Will it be meaningful to management/the team? Can we commit to achieving this goal?
Time-bound	What is the deadline for reaching this goal? When will we begin to take action?

Source: dearbornagency.com/2019/01/04/simply-sandra-smart-goals/

- Use each member's name to make goals more person-centered.
- Personalize goals for members and their specific situation(s).
- Remember to include specific action steps under the follow-up. Think about action steps besides "member will follow up with primary care provider," for example.

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SMART GOAL EXAMPLES

The goals below are examples, but may not be applicable for all members depending on member needs, their product or benefits available. Reminder, that for person-centered goal writing, when writing member goal, insert member's name or "I" prior to the goal. Please note that the statements "by the next review" and "by target date" listed below are examples. Any member-specific and applicable time frame can be used in its place.

Asthma	» Will self-report having an Asthma Action Plan in place by next review. » Will self-report having asthma medications in their home by next review. » Can verbalize appropriate inhaler use by next review. » Will self-report taking medications as prescribed by provider by their next review.
Behavioral Health/ Depression	» Will be able to list at least three coping skills by their next review. » Will establish care with Behavioral Health therapist by target date. » Will address concerns about depressed mood with provider by the next review. » Will self-report taking medications as prescribed by provider by their next review. » Will self-report reaching out to at least one member of their support system for social contact each day by their next review. » Will self-report following through with appointments with their new ARMHS (Adult Rehabilitative Mental Health Services) worker by the next review. » Will tell their therapist or psychiatrist when I have feelings of wanting to give up by the next review.
Caregiver Support	» Will reach out to support group by target date. » Will accept respite by next review.
Congestive Heart Failure	» Will self-report checking their weight as advised by their primary care provider by their next review. » Will be able to identify red flag symptoms by target date, such as weight gain, shortness of breath and swelling. » Verbalizes their understanding of when to call their primary care provider as related to their red flag symptoms by their next review. » Will self-report taking medications as prescribed by provider by their next review.
COPD	» Will discuss COPD action plan with primary care provider by next review. » Will verbalize and demonstrate correct use of inhalers by next review. » Will self-report having COPD medications in their home by next review. » Will self-report taking medications as prescribed by provider by their next review. » Will self-report provider visit yearly by next review.
Dementia & Alzheimers	» Will have supervision plan in place by target date. » Will self-report respite options by next review. » Will self-report provider visit yearly by next review.
Dental	» Will self-report preventive dental screening by target date. » Will self-report seeing their dentist for dental pain by next review.
Diabetes	» Will walk two times per week by the next review. » Will self-report having A1C checked within the last year by the next review. » Will self-report eye exam within last year by the next review. » Will self-report foot check within the last year by the next review. » Will self-report checking blood sugars as recommended by their provider by the next review. » Will self-report taking medications as prescribed by their provider by target date.

ER Use	» Will self-report using the Nurse/Care Line before going to the Emergency Room. » Will have a list of nearest urgent care providers by next review.
Falls/Mobility	» Will self-report daily use of assistive device by next review. » Will self -report any falls to provider, caregivers and Care Coordinator by next review. » Will remove all throw rugs in their home by next review to decrease falls risk. » Will accept grab bars in their home by the next review. » Will accept Personal Emergency Response System by next review.
Frequent Hospitalizations	» Will self-report understanding of ways to prevent hospitalizations by next review. » Will follow up with their provider as recommended by target date. » Will self-report taking medications as prescribed by provider by target date. » Will self-report having prescribed medications in their home by next review.
Hyperlipidemia	» Will self-report taking medications daily as prescribed by the next review. » Will self-report having lipid panel this past year or as recommended by their primary care provider by target date.
Hypertension	» Will report performing blood pressure checks as recommended by their provider by next review. » Will accept blood pressure cuff for home checks of blood pressure by target date. » Will have a system for recording blood pressure readings to bring to their primary care provider by target date. » Will self-report taking medications as prescribed by provider by their next review.
Pain	» Will decrease pain by 1-2 points on a scale of 1-10 by target date. » Will self-report taking pain medication as prescribed by provider by next review. » Will self-report visiting the provider who manages their pain medications by the next review.
Preventive Health	» Will have annual preventive physical by December. » Will self-report making an informed decision about completing a colonoscopy by goal target date. » Will discuss all needed preventive screenings with their primary care provider by goal target date.
Safety	» Understands risks of refusing services and will notify Care Coordinator by target if not met. » Will report following their emergency back up plan in an emergency by the next review.

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