SOUTH COUNTRY HEALTH ALLIANCE
Bringing Wellness Home

Care Coordination Training Handout

Goals, Interventions, and Outcomes

Definition of GOALS

Goals are broad-based statements that indicate what you hope to accomplish while coordinating care for the member. Focus should be how a health condition, disease process, and supporting services will be changed as a result of the successful interventions.

In summary, goals are global statements of the need or the problem(s) to be solved by care coordination/case management services.

Definition of INTERVENTIONS

Interventions provide an organized pathway to meet the GOALS. Interventions are operational, measurable, and describe specific things you, the member, the member's representative, PCP, home care agency, homemaker agency, transportation, and so on will be accomplishing.

Qualities of an INTERVENTION

S.M.A.R.T. interventions are interventions that are specific, measurable, actionable, reasonable, and time-framed. S.M.A.R.T. interventions can help you to better track care coordination/case management progress and set realistic expectations with the member.

SPECIFIC:	What kind of problem or which identified concern is to be addressed? *"What has to be done?"*
MEASURABLE:	How much, how many, and how will the problem/identified concern be resolved? *"What will be the end result?"*
ACTION-ORIENTED:	Use action verbs (examples on next page).
REASONABLE:	Results you can expect to achieve.
TIME-BOUND:	Give specific target dates for the intervention's achievement.

Definition of OUTCOMES

Outcomes provide a definition of how your client will be different as a result of the goals and interventions. Outcomes should be measurable and include action verbs that identify an observable behavior or situation.

Examples of GOALS, INTERVENTIONS, and OUTCOMES

Goals:

- Member will keep blood sugar levels within member's PCP-ordered parameters.

Interventions:

- Member will take blood sugar readings 3-4 times per day and write the number down in daily log book.
- Care Coordinator will identify and educate member about dietary changes to maintain blood sugar levels by 01-01-2019.
- Home Care Skilled Nurse will set up insulin syringes and review blood sugar levels weekly.
- Care Coordinator will receive monthly reports from the Home Care Skilled Nurse about member's management of diabetes.

Outcomes:

- Member will decrease visits to the Emergency Room for elevated blood sugar levels by 01-01-2019.

Examples of Action Verbs

Application	Comprehension	Knowledge	Analysis	Synthesis	Evaluation
apply	associate	cite	analyze	arrange	appraise
calculate	classify	count	appraise	assemble	assess
complete	compare	define	contrast	collect	choose
demonstrate	compute	draw	criticize	compose	critique
employ	contrast	identify	debate	construct	determine
examine	describe	indicate	detect	create	estimate
illustrate	differentiate	list	diagram	design	evaluable
interpret	discuss	name	differentiate	detect	judge
locate	distinguish	point	distinguish	formulate	measure
operate	explain	read	experiment	generalize	rank
order	estimate	recite	infer	integrate	rate
predict	examine	recognize	inspect	manage	recommend
practice	express	relate	inventory	organize	revise
relate	interpret	repeat	question	plan	score
report	interpolate	select	separate	prepare	select
restate	locate	state	summarize	produce	test
review	predict	tabulate		propose	
schedule	report	tell			
solve	restate	trace			
translate	review	write			
use	translate				
utilize					

Words or phrases such as know, think, appreciate, learn, comprehend, remember, perceive, understand, be aware of, be familiar with, have knowledge of, grasp the significance, are NOT measurable and should be avoided.