BEST PRACTICE GUIDELINES –
CARE COORDINATOR
GOALS AND BARRIERS

Individualized Care Plans: Addressing Goals and Barriers

Once the assessment has been completed, the next step in the process is to develop goals and address barriers with your patient.

- Establish goals and prioritize needs– consider patient's preferences and desired level of involvement
- Determine available resources and services to meet goals
- Understand the barriers and develop a strategy to address.
- Barriers could include such things as:
  - lack of transportation
  - literacy
  - cultural or religious beliefs
  - understanding of their condition
  - desire to participate in care coordination
  - ability to self-manage
  - hearing or visual deficits
  - financial
  - treatment side effects including medications
  - interpersonal relationships (with provider, care team, family, etc).
- Develop SMART goals:
  - Specific, Measurable, Attainable, Relevant, Time-limited
- Use of Confidence and Conviction scales - assess their conviction and confidence to make these changes
- Timeline for reevaluation
- Develop the goals with the patient and add to the care plan

SMART Goals

Specific, Measurable, Attainable, Relevant, Time-limited

S	M	A	R	T
• **S**pecific – This will keep me focused and have a place to start	• **M**easurable – This will help me to know if I am making progress	• **A**chievable – I want to set myself up for success	• **R**elevant – This is important to *me*	• **T**ime-limited – I will be able to see progress in the short-term

Conviction and Confidence

Assess your patient's willingness and confidence in achievement of their goals. The use of a ruler or scale such as the one shown below will help inform how important the goal is to your patient.

Conviction Ruler

0	1	2	3	4	5	6	7	8	9	10
Totally Unconvinced			**Unsure**		**Somewhat Convinced**			**Very Convinced**		**Extremely Convinced**

Confidence Ruler

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0	1	2	3	4	5	6	7	8	9	10
Totally Unconfident			**A Little Confident**		**Somewhat Confident**			**Very Confident**		**Extremely Confident**

Adapted from rulers developed by the Rhode Island Chronic Care Collaborative 2003

Retrieved from: http://www.ihi.org/resources/Pages/Tools/SelfManagementToolkitforClinicians.aspx.

Sample Goal

	Example:
1. Goals: *Something you WANT to do:* ________________________________	**1. Goals:** *Something you WANT to do:* Begin exercising
2. Describe **How:** _________ **Where:** _______ **What:** _______ **Frequency:** ______ **When:** ______________________	**2. Describe:** **How:** Walking **Where:** Around the block **What:** 2 times **Frequency:** 4 x/wk **When:** after dinner
3. Barriers: _____________________	**3. Barriers:** have to clean up; bad weather
4. Plans to overcome barriers:	**4. Plans to overcome barriers:** ask kids to help; get rain gear
5. Conviction ___ & Confidence ___ratings (0 - 10)	**5. Conviction** 8 **& Confidence** 7 **ratings (0 - 10)**
6. Follow-Up:_________________________	**6. Follow-Up:** next visit – 2 months