

## Care Management Plan (Goals of Care)

Below is a template to guide you in capturing key elements when setting goals with your patient. Generally, you will set one to three goals with your patient based upon the initial assessment. Continue to address each goal at every encounter, document progress towards goals, and modify or revise goals, as needed. In keeping with member-centric requirements, continue to review the goals with the patient to ensure they agree with the plan.

Start date:	Problem:							
Goal priority: ☐ High	al priority:   High   Medium   Low							
SMART goal (Specific, Measurable, Achievable, Realistic, Time-Bound)								
Identified strengths:			Identified barriers:					
1.			1.					
2.			2.					
3.	3.							
Interventions/action steps — Who will do what?		Comments (for example, specific barriers, outcome information)		Due date	Outcome date			
1.								
2.								
3.								
Goal two								
Start date:	Problem:							
Goal priority: ☐ High ☐ Medium ☐ Low								
SMART goal (Specific, Measurable, Achievable, Realistic, Time-Bound)								

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Identified strengths:			Identified barriers:					
1.			1.					
2.			2.					
3.			3.					
Interventions/action steps — Comments (for e		example, specific						
Who will do what?	barriers, outcome							
1.								
1.								
2.								
3.								
		L						
Goal three	Goal three							
	Problem:							
Goal priority:   High	Goal priority: ☐ High ☐ Medium ☐ Low							
SMART goal (Specific, Measurable, Achievable, Realistic, Time-Bound)								
Identified strengths:			Identified barriers:					
1.			1.					
2.			2.					
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Interventions/action steps — Comments (for e								
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1.								
2.								
3.								