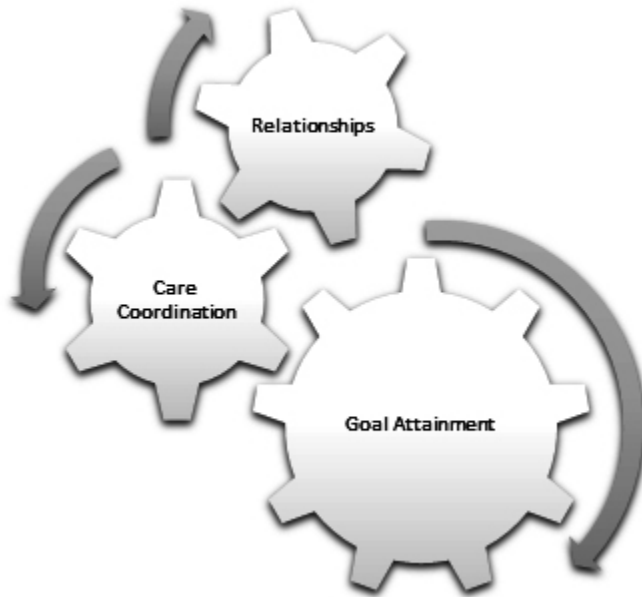


# Setting Goals with People with Complex Needs: A Collaborative Approach



People who have or who are at risk for complicated health conditions (e.g. those over the age of 65 and/or people with physical, intellectual or developmental disabilities) depend on person-centered care management to meet their needs, preferences and goals. This focused assistance helps them to create customized plans to organize and navigate medical, behavioral health and long term services and supports (LTSS). The individual's goals should drive care coordination, but to be effective, person-centered care management also requires effective communication and coordination amongst the individual, their health care providers as well as paid and unpaid supports.

Medical providers, care managers, LTSS providers, family and friends play different and complementary roles in helping an individual meet his or her goals. These providers and supports commonly have little or no formal affiliation, nor access to shared information. Care managers must establish relationships with others involved in an individual's care and communicate effectively with each one.

## **Use Communication to Develop Relationships, Build Trust and Coordinate Care**

---

To help individuals reach their goals, care managers must first understand what is most important to the individual. Goals, including medical and non-medical goals supported by LTSS are highly personal, and each individual has unique values and motivators.

### **Elicit Goals:**

- Understand the individual's history and current circumstances
- Get to know the individual and tailor the discussion accordingly
- Acknowledge the individual as the expert when eliciting goals and priorities

- Use motivational interviewing to understand why a goal is important
- Articulate the goal and confirm understanding: “Did I get this right?”

At times, clinical recommendations may differ from personal goals, or an individual’s long-term goals may seem unrealistic. Care managers can help individuals identify goals which are attainable within the available resources.

#### **Negotiate Goals:**

- Break long-term goals into smaller, more manageable steps
- Prioritize by importance, put “first things first”
- Identify a complementary or supportive goal to the primary goal
- Defer to the goal stated by the individual when there is unresolvable conflict

Once the goals are established, care managers can help individuals sustain motivation and the desire for change.

#### **Support Goal Attainment:**

- Monitor progress and offer encouragement
- Identify and address potential barriers
- Set expectations and assign responsibilities
- Identify measures of progress

When establishing goals, care managers and individuals should discuss how progress will be measured. Documenting progress and identifying facilitators and barriers to goals can inform changes to the care plan.

#### **Review and Update Goals:**

- Review goals, including progress and barriers, at regular intervals
- Document conversations about goals
- Retire or modify goals once attained or no longer desired

Reaching goals can be a long and challenging process. For more information, see NCQA report on policy approaches to advancing person-centered outcome measurement at: [www.TheSCANFoundation.org](http://www.TheSCANFoundation.org).

*The John A. Hartford Foundation, based in New York City, is a private, nonpartisan philanthropy dedicated to improving the care of older adults. For more information, please visit [www.jhartfound.org](http://www.jhartfound.org).*