



Practice Name: _____

Start Date: _____

End Date: _____

Plan Prepared By: _____

Review Date: _____

Goal Achieved: ____ Yes ____ No

GOAL PLANNER

Overall Goal:

Specific Goal:

Health Care Team

	Action Steps (Need To Get Done)	Facilitator (Oversees Action Steps)	Responsibilities (Individuals or Groups)	Completion Date
1.	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
2.	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
3.	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
4.	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
5.	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____

Potential Obstacles/Areas of Concern

Sources of Help

Scoreboarding (Metrics)

Method/By

Frequency

	/	
	/	
	/	
	/	

Upon Successful Attainment of Our Specific Goal (Reward):

“Initialing and dating this planner signifies my *commitment* to our achievement of this goal.”

Initials

Date

Initial

Date

Initials

Date

Review Date: _____

Goal Achieved? _____

GOAL PLANNER REVIEW

Specific Goal:

Reviewers:

Strengths:

Weaknesses:

To Modify:

Scoreboarding Notes:

Additional Highlights:

Next Steps:

Health Care Team: _____

“The outcome of this Specific Goal does ___ does not _____ warrant its continuation (with modification state above), as part of our hospital’s protocol.”

(NEW GOAL PLANNERS, AWARDS AND METRICS MAY BE ESTABLISHED ACCORDINGLY.)

<i>Initials</i>	<i>Date</i>	<i>Initial</i>	<i>Date</i>	<i>Initials</i>	<i>Date</i>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____