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Authors
Reuben, David B
Jennings, Lee A

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Putting Goal-Oriented Patient Care Into Practice

David B. Reuben, MD and Lee A. Jennings, MD, MSHS†*

ABSTRACT: New efforts have begun to transform healthcare to focus on patient-centered care. Such efforts will be facilitated by eliciting, operationalizing, and measuring the attainment of patient-identified goals of healthcare. This article describes a practical approach to goal setting and measurement that can be used in efforts to implement patient-centered care. **J Am Geriatr Soc 67:1342–1344, 2019.**

Key words: outcomes; chronic diseases; patient-centered care; patient preferences; goal attainment scaling

With the increasing focus on patient-centered care,[1] there has been more interest in engaging patients in setting personal goals and aligning care to attain these goals.[2] This approach has inherent value because it engages patients, establishes personal goals, and sets targets for patients and clinicians to plan a course of action and measure success. Some notable efforts to integrate patient goals into healthcare include Patient Priority Care[3,4] as well as integration of goals into the care of diseases, such as dementia[5] and diabetes.[6] In this article, we describe a practical approach to goal setting and measurement.

When establishing patient goals, it is valuable to use several metrics, including specificity, time frame, objectivity, and maintenance vs improvement. First, goals can be either disease specific or overarching, spanning across multiple diseases. They may be short-term (eg, symptom control) or intermediate steps toward a larger, long-term, often preventive, goal (eg, blood pressure control to prevent a stroke). Goals can also be categorized as objective or subjective. Objective goals are often linked to an observable situation (eg, a patient remains at home because a family member has taken leave from work to provide care) or an accomplishment (eg, walking independently after a hip fracture). In contrast, subjective goals reflect states of comfort or well-being (eg, less dyspnea). These are best measured by the persons themselves. Some goals can be operationalized as either objective or subjective. For example, a goal of pain control could be an objective goal (eg, not requiring opioids for pain control) or a subjective goal (eg, improvement on a pain scale). Goals can also be focused on maintaining the status quo (eg, continuing to drive) or improving the current situation (eg, being able to sleep without hypnotics).

Regardless of goal type, the process of providing goal-oriented care follows a series of steps (Figure 1). The underlying foundation of all goals should be the patient's values. Usually, it is reasonable to assume that patients value living a long life free of incapacitating illness. However, ascertainment of the patient's underlying values becomes important when trade-offs must be made between competing goals (ie, not all are achievable) or when a short-term goal (eg, being discharged from the hospital directly to home after a hip fracture) may not reflect long-term wishes (eg, being able to walk independently). This is commonly the case for those who are frail or persons with multiple chronic conditions and when focusing on overarching goals.

The SMART (Specific, Measurable, Attainable, Relevant, and Time-Specified) framework is helpful in operationalizing personal goals.[7] For example, a patient's goal to lower his or her risk of diabetes might be made specific by identifying the goal outcome (eg, to lose 10 pounds) and a time frame. Thus, goal setting is inherently linked to establishing specific measurements and outcomes, and an appropriate care plan cannot be created until patients and clinicians agree on these.

For objective goals, individually desired outcomes can be identified and then scaled through goal attainment scaling (GAS),[8] which often uses a five-point scale to reflect the expected outcome (0) as well as worse than expected (−1 or −2) and better than expected (1 or 2) outcomes. For subjective goals, patient-prioritized, patient-reported outcome measures (PROMs),[9] through which patients provide their perceptions and feelings about themselves, may be more appropriate. Thus, the two approaches are best viewed as complementary. In fact, they can be combined (eg, setting a goal of improving

From the *Multicampus Program in Geriatric Medicine and Gerontology, David Geffen School of Medicine at UCLA, University of California, Los Angeles, Los Angeles, California; and the †Reynolds Department of Geriatric Medicine, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma.

Address correspondence to David B. Reuben, MD, AGSF, Multicampus Program in Geriatric Medicine and Gerontology, Division of Geriatrics, David Geffen School of Medicine at UCLA, 10945 LeConte Ave, Ste 2339, Los Angeles, CA 90095-1687. E-mail: dreuben@mednet.ucla.edu

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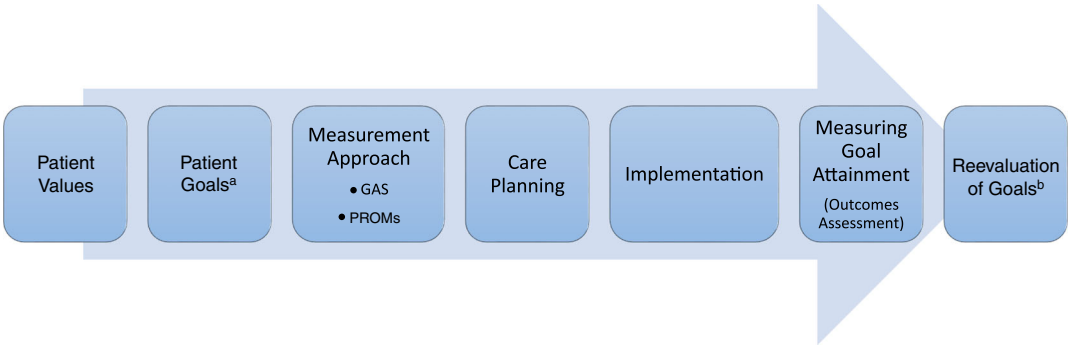

Figure 1. Steps in Goal-Oriented Care.
[a]Patient goals may be categorized as:

- Disease specific vs overarching
- Objective vs subjective
- Maintenance vs improvement
- Short-term vs long-term

[b]Reevaluation of goals may include:

- Discarding goals
- Modifying or recalibrating goals
- Setting new goals

Abbreviation: GAS, indicates goal attainment scaling; PROM, patient-reported outcome measure.

by a specific amount or percentage, as measured by a specified PROM).

Both measurement approaches have their advantages and disadvantages. PROMs have extensive validation and psychometric data to support their use. They are shelf ready and easy to administer. Moreover, PROMs can be followed longitudinally and potentially used to compare performance of medical groups, health plans, and, perhaps, individual providers. However, PROMs do not fit well for patients who are unlikely to improve or who are expected to decline, and not every goal has a validated PROM that is a good fit. Finally, the meaning of PROM scores or the interpretation of changes may not be clearly understood by patients. GAS frequently takes longer, requires a skill set to administer, and may lack the psychometric rigor that would permit comparisons.[10] Finally, GAS is not a measure of health but rather a measure of how well healthcare helps patients meet personal goals. Hence, conclusions about the state of a population cannot be drawn by this approach. Nevertheless, GAS captures what matters to individual patients and may better facilitate care planning compared to PROMs.

Once goals are selected and outcomes established, clinicians and patients can turn to care planning and implementation. Techniques, such as motivational interviewing,[11] can facilitate prioritization and engage patients in completing the necessary actions to meet their goals. At the specified time for outcomes assessment, goals may have been met (or partially met) or unmet, perhaps because they were too difficult or are no longer relevant or desired. This leads to reevaluation during which goals can be discarded, modified, or recalibrated (ie, same goal but different metrics for success), or new goals might be set.

Some practical issues must be recognized. The goal-setting process for disease-specific goals may take only a few minutes and can often be integrated into primary or specialty care. In contrast, setting overarching goals usually takes longer, in part because patients, caregivers, and many health professionals are not accustomed to thinking in this manner. Because these discussions are time-consuming, primary care providers and specialists might not be the most efficient professionals to lead patients through the process. Yet, primary care providers who understand the medical issues that may influence the "attainability" of a patient-identified goal and sometimes have long-standing insights into the patient's values may have the best perspective for helping set goals. Further research on implementing GAS into practice should also focus on how best to determine whether goals are achieved, including use of PROMs for this purpose, and to identify opportunities for treatment aimed at improving these outcomes.

Goal-oriented patient care is a new and novel approach to caring for patients. It will require further development of measurement approaches, fundamental shifts in the culture of medical practice, and the acquisition of new clinical skills. A combination of traditional and goal-oriented care will likely best suit the future of healthcare, a future more focused on achieving what matters most to patients.

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