Collaborative, Patient-Centered Goals Are Key for Home Health and Hospice

SMART Goals Are a Helpful Model for a Patient-Centered Approach
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Consider the “5 W’s” (and one “H”)

Specific, Measurable, Achievable, Relevant, Time-Bound

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Collaborative, Patient-Centered Goals are Key for Home Health and Hospice

Home health and hospice care offer both challenges and opportunities that are unique within the healthcare arena. The challenges for clinicians come both from the patient population they are serving and from the home care setting itself.

Home health and hospice patients are usually older adults with multiple comorbidities or chronic conditions, and family and caregiver support networks vary drastically. Unlike in acute and long term care settings, these patients often function with real autonomy, including in their compliance (or noncompliance) with treatment and care plan regimens. We know that patients who are engaged in the goal-setting process and invested in the outcomes are more likely to adhere to their plan of care and treatment. What patients are willing (and able) to do to accomplish a goal is critical to its achievement, which means that collaborative goal-setting is crucial. Indeed, home health and hospice clinicians must be care partners with their patients, and this partnership must begin at the assessment and care planning stage of the relationship.
Assessing the patient’s reality

A disease-centered approach may be appropriate for some patients, but it is ill-suited for patients with multiple chronic conditions or comorbidities, or those facing end of life decisions. For home health agency (HHA) and hospice patients, patient-centered care and quality outcomes rely on goals that are individualized to the patient’s unique needs, preferences, and priorities. A comprehensive assessment must go beyond OASIS (Outcome and Assessment Information Set) or HIS (Hospice Item Set).

While the home setting presents distinct challenges, it also offers opportunities for more comprehensive assessment and collaborative goal-setting. The clinician in the home can help patients identify and articulate priorities and develop goals based not just on medical diagnoses but on the patient’s individual, complex reality. That is, the clinician can consider and evaluate all aspects of the patient’s medical, physical, cognitive, psycho-social, emotional, and spiritual needs and values. A patient’s reality can include:

- Medical diagnoses and symptoms
- Medication requirements
- Pain management desires and restrictions
- Physical surroundings and environment
- Physical abilities and limitations
- Cognitive and emotional abilities and limitations
- Psycho-social environment
- Psycho-social and spiritual needs and restrictions
- Religious and/or cultural requirements and restrictions
- Family and caregiver support networks
- Habits and routines
- Financial and/or legal restrictions
Using SMART Goals Helps Drive a Patient-Centered Approach

Patient-centered goals should consider the individual's unique reality. They should be prioritized based on that reality and include individualized target dates or time lines. Patient-centered goals can address any aspect of a patient’s reality, including:

- Diagnosis-specific treatment outcomes
- Reduction or maintenance of symptoms
- Reduction or maintenance of pain/suffering
- Knowledge and understanding of medical conditions or symptoms
- Maintenance of/improvement in physical or cognitive function
- Improvement in well-being and/or coping skills
- Maintenance of/increase in independence
- Maintenance of/improvement in quality of life
- Extension of life expectancy
- Renewal of hobbies and activities
- Ability to attend a specific function or event

Family and caregiver goals must be considered as well. Especially in a hospice or palliative care setting, these may differ significantly from those of the patient and/or clinician.
Using the SMART goal model is one of the best ways to ensure that goals and outcomes are patient-centered and prioritized. “SMART” is an acronym that was first published in 1981 by George T. Doran (“There’s a S.M.A.R.T. way to write management’s goals and objectives”), who defined it as Specific, Measurable, Assignable, Realistic, and Time-related. The SMART concept has been around a lot longer, however, and may have been known as early as the 1940's-1950’s as a goal-setting tool for business management. Through the years SMART goals have been used in business, education, healthcare and personal goal-setting, and the acronym definition has evolved over time to the current Specific, Measurable, Achievable (or Attainable), Relevant, and Time bound.

When developing SMART Goals, it is helpful to address the “5 W’s” (and one “H”):
• **WHO** must be involved in the progress towards this goal?
• **WHAT** does the patient/clinician/caregiver want to accomplish through this goal?
• **WHICH** aspects of the patient’s reality must be considered in the identification of and progress towards this goal?
• **WHEN** will the goal be accomplished?
• **WHY** does the patient/clinician/caregiver want to accomplish this goal (motivation, benefits or broader end-goal)?
• **HOW** will progress toward and attainment of the goal (outcome) be measured?
Patient-centered SMART goals should be:

**Specific**
- Is the goal clear, concise and complete?
- Is the goal concrete and measurable? (i.e., “patient will be able to list…” instead of “patient will know”)
- Does the goal answer the “Who” (patient, clinician or caregiver) and “What”?

**Measurable**
- Can progress toward the goal be objectively measured and recorded?
- How will progress be measured?
- Are there interim steps necessary to the achievement of the goal? (If so, consider breaking it down into smaller interim goals)
- Does the goal address the “How”?

**Achievable**
- Is the goal attainable, realistic, and reasonable given the patient’s reality?
- Does the patient have the knowledge, skills, and ability necessary to achieve the goal?
- Should the goal be broken down into intermediate steps or interim goals?
- Does the goal address the “Which”?

**Relevant**
- Is the goal relevant to the patient’s reality?
- Is the goal in keeping with the patient’s priorities and values?
- Does the goal address the “Why”?

**Time Bound**
- Does the goal have a clearly defined, specific time-line or target date?
- Is it possible/realistic to put a target date on the goal? (If not, it should be reworked)
- Is the time-frame realistic and reasonable for this patient? (If not, consider breaking it down into smaller interim goals)
- Does the goal answer the “When”? 

Collaborative, Patient-Center Goals Are Key for Home Health and Hospice
Patient-centered SMART goals and your EMR

Your HHA or hospice EMR (electronic medical record) can be an invaluable tool for goal-setting and outcomes management.

Your system should prompt for goal-setting by diagnosis and comorbidity, and allow additional goal entry based on the clinician’s comprehensive assessment. Clinicians should be able to identify, record and chart on behavioral goals, health and well-being goals, and care or service goals. For hospice and palliative care patients, it is crucial that your EMR enable goal setting for caregivers and families as well.
Two key components of a SMART goal are measurability and time. Your EMR system should prompt for achievement target dates and facilitate outcomes measurement charting.

**The Team Approach**

Once patient goals have been developed, it is crucial that all clinicians and caregivers understand the documented goals. This is where your EMR can really help. No matter who identifies or documents a goal, it is available to all members of the interdisciplinary care team. Everyone will be able to view, monitor and verify the patient’s goals and outcomes. This communication and coordination among care providers, based on a shared understanding of patient-centered goals, can directly impact patient outcomes.