Kessler Institute for Rehabilitation 8th Annual Stroke Conference: Part 4 of 8 Working SMARTAAR to Achieve Functional Outcomes

Recorded October 2019. Listen to it here.

GRETCHEN MARCH: 00:04	[music] If we write really excellent goals, you have a great treatment plan. Your day is so easy. So the time it takes you to really think about real, valid goals is worth it.
ANNOUNCER: 00:18	Welcome to the eight annual stroke conference Breaking Barriers. There's more to getting home than walking. In this lecture podcast, Gretchen March of Kessler Institute for Rehabilitation presents Working Smart to Achieve Functional Outcomes Using ICF Framework for Goal-Writing and Treatment Planning. For more information about Ms. March, read her bio in the program notes. This conference was sponsored by Kessler Institute for Rehabilitation and was a one-day event that provided participants with an understanding of the multi disciplinary approach to rehabilitation that enables stroke survivors and their families are caregivers to rebuild their lives. Discussion will focus on communication, motivation, spatial neglect, sleep issues, bowel and bladder management, and community integration.
MARCH: 01:17	So what we're going to talk about now is using the ICF framework. Are people familiar with that? The International Classification of Functioning? Back in the early '2000s, the World Health Organization wanted to kind of stabilize the language around therapy and rehab and goals and things like that so that, wherever you were in the world, we were all able to speak the same language. I don't know how far it's taken off but it's a great idea and a lot of really good concepts. So I want to try and improve understanding of the purposes of goal setting to engage them in their rehab patients, support patient-centered clinical practice and team coordination, look at improving and understanding of the factors that affect development and use of goals in rehab. If we write really excellent goals, you have a great treatment plan. Your day is so easy. So the time it takes you to really think about real, valid goals is worth it. To increase clinician skills in working collaboratively with their patients to develop patient-centered goals and rehab plans. So the whole kind of concept from these previous lectures has been really involving your patient and making it about them. And to provide clinicians the ability to write, review, and use patient-centered smart rehab goals that support rehab practice using the SMARTAAR goal process which we'll go over that. So this is a great slide because it talks about the traditional versus the enablement approach. Now, enablers are bad, usually. When we say, "Oh, you're an enabler." That's something we don't want to be. Well, in this world, we do because we want to enable our patients to be their own advocate. We want it to be about them and not us. So let's take a look here at the traditional model. There's a patient dependency. So the health professional takes responsibility for the treatment plan.
MARCH: 03:05	And if you think about your own practice, and it's good to be honest when you think about it, you do your assessment, you write everything down, you sit down, if you're luck, right then but usually at lunch or before or whatever time it is that you are doing all of the notes, and then you write the treatment plan. And then you meet with them the next day and say, "This is what we're going to do." The staff in the traditional approach are the doers or the fixers. So the work is being done when the patient is being treated. It's like, "Let me adjust this or let me fix that or let's plan to do it this way." Individual assessment and care planning is protective of discipline and practice.

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So in a traditional model, there's still-- even though we've evolved a whole lot since I started practicing, there's still the OT, PT, "Oh, I don't know why they're doing that. I should be doing that." Or the speech, OT, "Why are those speech people in the kitchen with my person?" There's a little bit of territorialness that goes on still in a traditional approach. You do not want to work out of your scope of practice, of course, but there are areas of overlap that we still kind of struggle with a lot of people. There's a lack of continuity that leads to duplication. So in a traditional approach, we're kind of working side by side observing each other but still in silos. So you're focused on your plan, I'm focused on my plan, the speech therapist is focused on the other plan, and we may not realize if there's duplication if we're kind of going through the day with our head down. So if we're not really expanding and looking, I think a lot of us who work in healthcare are used to having weekly conferences and updates and things like that. And if you're covering for someone, you're pretty good at finding out the information because you don't know the patient. So you're looking through what have they been doing and then you notice, "Oh, they're doing the same thing."

MARCH: 04:58

And we all know that for reimbursement, duplication of services is really a huge red flag to just say, "No. We're done." And there's a little bit of lack of communication between the teams. And I don't mean complete lack but I think it's not as tight in a traditional approach because we're kind of moving down those pathways side by side on our own. The enablement approach is based on patient empowerment. So the aim is to maximize self-care at all levels. So like Dr. Adler was talking about the woman who wanted to be able to eat the ice cream. Everybody worked together. PT did not go off and say, "Well, I'm still going to try to do the transfers." That wasn't the main focus. We worked a lot. They got more speech than PT because of those reasons. So you're able to flex how you provide your services. Staff are enablers. Look at that, isn't this great? You finally get to use that in a positive way. The work is done once the patient is enabled. So what we were talking about a little bit before with the transtheoretical model of change, once you get that person and you're matching them at their level, they're more engaged to want to do things. So part of our treatment plan has to include enabling them to take charge of their care. Teamwork is increased, use of scales and experience within teams. So if somebody is better at something than something else, you kind of negotiate. It's like, "Yeah. This session, I'm going to focus on this. I'll let you know how it goes. They might need more practice in your session." So but we don't always do that as well as we could, I think. Continuity of care. There's a much more seamless transfer of care across the services in the enablement approach. And there's improved communication between teams. So all positive things. And traditional isn't necessarily negative, it's just more restrictive. So I don't want anybody to think that if you're doing it that way, that I think that's terrible. It's not. It's what's the norm in practice.

MARCH: 06:55

Don't do this to me today. Okay. So in summary, the enabling approach is an intervention in which the healthcare provider recognizes, promotes, and enhance the patient's ability to control their health in life. And that's what Ariel was just speaking about, right, with relation to exercise? It aims to achieve patient empowerment. The

staff acting as enablers or facilitators to get the person up and running and on board and successful. It's increasing teamwork and increasing the use of clinicians skills and experience. So it allows you to do a lot more mentorship with each other in a team, improve continuity of care, and improve communication. So if you look at this diagram, we have the clinician-driven treatment plan and the patient or goal-driven treatment plan. And typically, in the clinician-driven plan, the treatment plan is developed and we identify the goals. So we do the assessment and we think, "Okay. They're having trouble getting out of bed. They're having trouble getting on the toilet. They're having trouble eating. So these are the things we're going to do. These are the things we're going to practice. These are my goals." After you get that, you identify those goals. But with the patient or goal-driven treatment plan, it goes back to that initial assessment when you're doing your evaluation and you explore with the patient what are your important things to get you home. What are your goals? What do you need to do to be successful at home? And so after that, the clinician will sit back and write a treatment plan based on that. So you see the difference? A lot of us are probably still on the left, right? Because that's what we've always done. So it's one of those situations.

MARCH: 08:41

So this should look very familiar to you from Ariel's presentation. Hers [inaudible] blue boxes, though. Mine aren't blue. But it's the same idea, that the disorder or the disease, the ICD-10 code is the health condition. And within that condition, there are all of these areas that can be affected. So you have the body function structures which are the impairment levels, things that are broken that need to be fixed. We have the activity category, which is the activity limitation. So they can't get dressed. They can't get on the toilet. But they can't get on the toilet because they have no sensation and they have a left neglect and they have no idea where their leg is in space and they fall every time they stand up. And then you have the participation level. So how is this impairment and this activity problem affecting their ability to participate in their quality of life daily, social goals? I think Ariel went over the environmental factors and the personal factors really well. So I'm not going to go over that again but you do have to consider those two things as well. So how the person feels about something and how well their environment can sustain. And those are areas of opportunity as therapists in goal writing to look at what kind of things are their barriers. So if they don't have a big support system, can we get them independent? It's okay to not always have someone. Just because someone is 90 and they lived alone and now they had a stroke, they're okay. Maybe they're not 100% but maybe they're doing well. And you can teach them and they're very reasonable. They're not the kind of person who's going to try and do crazy things. Can they go home again? A lot of times, people say, "Oh, they can't. They're 90." I don't know. They've been living there before. So it's thinking like that, I think. So here's a good little table that we're going to spend some time thinking about and if you-- we're going to talk at the panel but if you have any questions throughout the talk, you can feel free to ask them as well.

MARCH: 10:41

But if you look at these three columns, you have the impairment or body part level goal, you have an activity or whole person type goal, and then you have the

participation as the whole person in a social context goal. So the first one is something that you might see that Katie will be able to comprehend the five step written instruction. Has anybody written a goal like that? Yes, no, maybe not? Okay. When you move over to the activity level for the same person, she'll be able to follow a recipe to make a cake. So that's kind of the long-term goal because she's not going to make a cake if she can't follow the instructions. So the short-term goal is the impairment that's a problem. Now, depending on your discipline and depending on the problem, I think this is where this team collaboration can be really, really phenomenal because if I have somebody who has a lot of problems with the positioning of their leg during gait and they're not following through with their sequence and they can't turn to get on the toilet, I can continue to practice the toilet transfer but if I collaborate with the PT and they know the problem I'm having in the toilet, they can do things that I'm not trained to do to facilitate getting them to that point. So it might be the PT might be working more on the impairment thing for the goal and the OT might be working on the activity and the long-term goal for everybody is to be able to be home independent and not need help on the toilet. Does that make sense? Another example would be Steven's hip extensor strength will increase from three our of five to four out of five. Now, if you tell the patient, "Hey, today, we're going to work on increasing your hip flexor strength." What do you think? They're going to be excited about that? Do they even know what you're talking about? Do you think that they would want to stay there and do it? They'll be like, "Oh, okay. Great. What does that mean?" So like Ariel said, if there's a value attached to it, if you need to work on that hip extensor strength so that you can stand up and get in your car, that's important.

MARCH: 12:33

So the activity level for that goal would be he'll be able to independently transfer from his wheelchair to his car. And then when you move it out to the ultimate goal for this patient is he'll be able to join his friends at their weekly outing at the pub. Because this is from Australia, just so you know. Just so you know. His mates. And I don't have a good Australian accent, so I won't do that for you. Another type of goal that you could look to see is like Joan's anxiety will be decreased by three points on a certain scale. Again, that's sort of a weird way to measure it because do we think about scales that we use? But we do write these goals because I review a lot of charts and I'm telling you, everywhere I go-- these goals are out there. Joan will be able to in the company of unfamiliar people for greater than 45 minutes without experiencing panic attack. So that's her activity level goal. She has to be able to be around people, to be in a meeting at work or something. She'll attend her daughter's ballet recital. So now there's going to be 200 people there. She's got to be able to sit there and not have the problem. Let's see. David's deep neck flexor strength will improve from a grade two to four. See now, I'm the person you tell me that, I'd be like, "What are you talking about?" But if you attach the activity component to that, he'll be able to work at a computer for four hours without experiencing pain greater than 3 out of 10. But then you're going to have to teach him how to monitor his pain scale. But that's all valuable stuff. So you see how when these goals are really specific like this, you're able to create a really robust treatment plan. And the participation level goes-- he'll

return to work four hours a day, three days a week because that's what he wants to do. He doesn't want to lose his job.

MARCH: 14:22

So, again, you want to look at the influences of the activity and participation level activities. There are social and culture things. So your whole identity of who you are if you can't go back to work. What am I going to do? The need to fulfill your social role. So before, you were the primary person bringing all the money in. What's that do to a person if they can't do that after a stroke? The need to meet personal and environmental demands and that's more at the activity level, being able to just have access to things like Ariel was speaking about with the fitness centers. And the need to accommodate personal preferences. So the relationship between goal setting and participation activity in impairment level goals goes something like this. The patient goal is usually the participation level goal. When you do the interview correctly, what do you need to be able to do? What is it that's most important to you following the stroke, that you feel the loss of, that you want back? However you say it to appeal to them, to get that level but don't just let them say, "I want to walk." Because you can probe a little more like, "How much walking did you do before?" "Oh, I used to walk three miles in the park every day." That's a different person than the person like, "Well, I used to just walk into my kitchen and back and forth." Doesn't mean you're not going to work at it but just saying, "I want to walk," is very basic because they're only thinking about what they can't do right now. My impairment is I can't walk. So my goal is I want to walk. But what do you want to walk for? Well, I need to walk because I do all the supermarket shopping myself and I'm the one who has to go and the store is very big and this is what I need to do. So when you get that participation level goal, then the next phase is the patient steps and those vary between participation and activity, their impairment goals and the assessment results from your evaluation. But the action plan, the intervention and assessment regarding the impairments and other actions to achieve a step become the action plan.

MARCH: 16:22

So you're starting from the top working your way down to the specific. Again, the patient goal is participation generated and it's more likely to come from the patient themselves. The patient is focusing on what activities they need to do but the action plan is more likely to be generated by the clinician because you have the expertise to help them organize the activity, assess the activity, and figure out why it's breaking down. Again, if they don't know there's a problem and the awareness component isn't there, writing a good goal that's really clear to them is going to help you not only make them more aware but probably make them more successful. How many people have heard of SMART goals? Yeah, right? So our current electronic documentation systems-- and different people have different ones. So some people have free text. How many people can have a free text option in their goal writing? How many people have absolutely no choice and it's all click off? Somewhere in between, you have access to writing them but you don't use it. You just click off and that's okay. This is not judgmental. It's like a no-judgement zone like Planet Fitness. It's all good. It's all good. Because the whole point of these conferences and things is to get together and share information that may be helpful. And when you hear it and you think about it, you're like, "You know what? I do do that. I don't want to admit it but I do do that."

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You catch yourself. So your awareness goes up the same way you train your patients for awareness. You start to think differently and you'll find some amazing things can happen. So the SMART stands for Specific. So your goals have to be specific. They have to be measurable. They have to be achievable, relevant, and time-bound. So if you include each one of those things in every goal you write, it'll be very clear to you what you need to do with your patient.

MARCH: 18:22

The patient will be very clear why they're doing it and it does take a little bit of extra time than clicking off a goal. So a typical goal for a person in rehab. They had a stroke, they come in, you do the assessment. They can do - I don't know - 50% of the transfer. They need you to help them 50% of the time. So what level are they? Mod, right? They're at that mod assist level, right? So you're going to write a goal, you do your assessment and why can't they-- what is the reason that they're mod assist? Where are they having the problem? So let's just pretend that they can stand up pretty well but when they take the steps to turn, they only turn to the right and they don't really seem to follow with their left foot. So they potentially could have a neglect and they have a decreased awareness of where they are in space. So they're great in a straight line, they look fabulous. You think, "Oh, no problem." You go to get them to turn, they do this. The walker is here, they're going all the way to the right. They're doing the 360 instead of the 45. So you know there's something going on. So when you have that person, a typical goal you meet, what would their long term goal be? What would you want their long term goal to be? Now, currently, if you had that person and you write a goal. All right. Nobody wants to say it. So I'll say it. You'd say something like, "A patient would be modified independent with his transfers by discharge." Something like that? Familiar? Okay. So you have that in there. And the short term goal would probably say something like, "Maybe we would address the turn." But a lot of the times, people don't. They'll just write, "Patient will be closed supervision in one week." So when you think about it, does that really measure anything? No, right? It's reporting a status. Now, we need to give that status and we need to show change for insurance companies, for sure.

MARCH: 20:17

So I'm not saying you don't want to include the level or some way of identifying how you're measuring it but I think that we fall into the trap of letting them say that's what they want. Because I think if we did the other way, they still wouldn't deny this because it's so clear. So I think you be the judge. So let's look at some elements here and some examples of measurable goals. Cognition. How many people write separate cognitive goals? It's what I thought, very few. How do you address cognition in your goals or do you? So say you got that high level person Dr. Adler was talking about and he's kind of impulsive and his judgement isn't very good. He seems a little unsteady on his feet but he thinks we can climb on the step stool to get the light bulb in the-- but he can't even really walk a straight line yet. So when you have that problem and you're working on awareness, there's some place that we need to insert that. Otherwise, they become the person who they can walk 150 feet, they're fine. But they're not fine. They can't walk their way through the hospital without running into something or they can't find their way in the hospital because they lose track and get distracted and they just go into any room that they see. So that's not a successful

discharge, right? But on the insurance level, oh, they went from mod assist to, well, now they're mod walking with their walker 150 feet. And I'm like, "Okay." So we can change some of that by including things. So let's look at how much. So Jova returned to work 20 hours per week over four days by the end of March 2013. That's pretty clear, right? And you're telling the insurance company when you think it's going to happen-- well, it's passed. She's back to work by now.

MARCH: 22:05

Jack will host a dinner party including cooking a two-course meal for himself and three friends at his home within 12 weeks. Now, we know we don't have 12 weeks. So within 18 to 20 days. So of course, you're going to scale it to the point that you can. But if somebody used to make their own breakfast, they'll be able to make their breakfast including cleaning up after, cooking eggs, whatever. You can define what they usually eat for two people and be able to follow the instructions and adequately gather all the items needed without any supervision. And then they do it and they need supervision and you haven't met the goal yet at the weekly but the goal is still there and you know what you're doing. Every couple of days, you're going to test it out again. John's satisfaction with his ability as a father will increase from self-reported score of 2 out of 10 to 8 out of 10. So there's some set goals in here. Now, the next one is how often. Karen performed the family grocery shop every week. So if she doesn't do it, she doesn't do it. Karen will increase her work days from two to three days a week. Jack will make his bed every day. Joel will make contact with a friend twice a week via phone or face to face. So it's different than just saying what level they're going to be at. If they've had a stroke and they're impaired and they need to use an assistance device, for example, you can say that she'll go out to lunch with her friend once a week using transportation available and read the bus schedule accurately without assistance or list minimum prompts to find the correct time or-- so if you know how you're going to do it, instead of just using things like cues-- because with cognition, we always say cueing because we don't really know how to define it sometimes.

MARCH: 24:02

So you have to think about it. Verbal cueing is really dependent on us. So if we're not really good at it and we jump in too soon, we're overcueing them and then they're getting penalized for meeting cues that maybe they didn't really need. So cueing by itself isn't a great way to measure things. How well? Linda will complete her morning hygiene routine within one hour or she'll be able to follow a five-step written instruction. So if she's trying to get back to work and she has to schedule people at a doctor's office, she has to be able to multiply look at different steps, right? Oh, where am I in this step? Oh, the phone rang. How do I get back? Things like that. And she has to be able to get herself ready within a certain amount of time. So think about your own morning routine. You woke up this morning. How long does it typically take you to get ready? You're working people, right? Some people I would say an hour or less for most people. I'd say most people are in the half hour or less and some people are down to the 15 minutes but don't-- if you're extremely efficient, don't think that that's the norm. But I would say that's reasonable. If it takes someone two or three hours to get dressed like I had some people, some stroke patients where they were retired and they were fiercely independent, they wanted to do it, and it didn't matter

that it took them two hours to get it together. They would take a rest break in between, they'd do part of it, then they'd put their robe on and go down and have breakfast, then they'd go back and do their dressing. But they have time to do that. So it has to be realistic for the person as well. So there is no right way or right amount of time to get dressed but it has to fit in the context of the person's life. And lastly, what level of independence or assistance? Peter will cook the evening meal with assistance only to cut the vegetables. So if he can do that, he's met that goal. Maybe next, you want to write some kind of goal where he can do cutting activities when he meets that goal.

MARCH: 25:59

Jack will walk home from the bus stop with a walking stick - walking stick is a cane here but in Australia in a walking stick - and stand by assistance. So we all kind of are good at that bottom one but if we add some of those other elements, I think you'll have a much more robust plan. SMARTAAR, the A-A-R that they've added in Australia - I did some research - they have an action plan, an achievement rating, and reporting results. So specific is what the patient wants to achieve specifically, not generically. Measurable. Is it easy to determine when they goal has been achieved and what is the desired standard of quality for achievement? So how do you know when you met the goal? So in our old scenario, if you want them to be mod I for all their transfers and that their weekly goal, their short term goal is at mod assist and that their weekly team, they fluctuate between mod assist and close supervision, it's not super measurable, right? Why are they having the fluctuation would be nice to know. and how do you measure when that thing goes away? Is it the turning piece? Is it the piece where they can't pay attention on their left side? So what is that component that will make it even more measurable? Achievable. Is the goal realistic for the patient at this time and is the goal achievable given current resources? So we've all had the person who's probably in that pre-compilation phase who's a stroke patient and says, "Well, I'm going to be fine because when I leave here, I can drive." Now, you know they can't drive because they have a-- this person has a neglect. So that would be bad. And they're having difficulty organizing themselves in a small clinical environment. So it's probably not going to happen right away, right? So just because someone says a goal, it doesn't mean you have to go with the goal. That's not the message here.

MARCH: 27:50

We also have to counsel them and work on the awareness of is the goal appropriate and is it achievable. I would say to that person, I'd say, "I think that's a really good long term goal and I think we should keep that window open. But right now, let's think about the last three days when every time you walked to the kitchen, you ran into four things. If you're running into things when you're walking, what's going to happen when you're in a vehicle? You could hit people, you could hit yourself." So helping them kind of keep that moving. Is it relevant? Have they stated they want to achieve the goal and is the goal relevant for the services requested? So if somebody wants to eat and they're coming to PT and they're saying, "All I want to do is eat." I'm not going to do it. The great one in OT, it happens all the time, "I just want to walk." I'm like, "Well, that's not my thing." So what do we want to walk for? And I, as an OT, don't walk people till their car or their bed because if they need gait training, they

need PT to walk. So it has to be relevant for the service requested and you have to say, "Well, let's think about what we talked about yesterday. When we set up that list and that treatment plan together, you also wanted to be able to play with your grandchildren on the floor," like Ariel said. "So let's look at the transition from sitting on the floor to getting up and then you can practice your walking in PT." How long do you think it'll take for the patient to achieve the goal? This is kind of tricky because we don't always know but once you start to see them that first week, you can get a sense of how well they're adapting to the goals. Like are they making movement toward it? Is there absolutely no movement? Then you might want to reassess is the goal too high because that happens sometimes. How many times have you picked up a person that someone else did the eval, you pick them up and you're like, "How did they think this was going to happen?"? And sometimes it happens because maybe you're a neuro specialist and you're working in an ortho gym or a cardiac gym and you're not sure what that goal is. So you do the best you can. So you can always revise your goals. That's the message.

MARCH: 29:48

The action plan. What does the team need to do to achieve the goal? So this is where that team communication comes in. You're working together. I'm going to focus on this, you focus on that. The achievement rating is using a scale to describe the degree to which the patient has achieved a goal. So I think we have the care scores now, GG scores in rehab. Fin is no more, Lauren? Fin? Bye-bye, Fin. Bye-bye, Fin, everyone. Anyone who did the Fin, bye, happy. And reporting goal outcomes. Who needs to know about the progress the patient made today? So the patient needs to know. In those care partner meetings when we meet with the families regularly through their stay in rehab, the families and caregivers need to know. And our insurance companies need to know. And don't worry about that, it's the same thing. So in summary, patient-centered participation goals are the best. So when you're thinking long term, think about what that patient wants to do in their life. If you think about our long term goals, they'll be independent with transfers to all surfaces, and we think, "Okay. Is that really exciting in life? Okay. I can get on the toilet. Yay." It's a very limiting kind of way of thinking. Use the ICF conceptual model as a guide. If you write your goals in a SMART format, you'll find that you have really clear ways to measure. So how many times have you wanted to upgrade someone? You want them to be able to use the toilet in their room because toileting is one of the single biggest reasons people don't get home, incontinence and toileting. So if we take that as a goal, what can we do to help them? What's going to be measurable in that? So it's going to be they're going to be able to find their way, not have collisions. They're going to be able to turn the most safe and effective way.

MARCH: 31:43

So instead of turning this whole big way to the right, we're going to teach them how to put their hand in a certain place and maybe make that safer. And just remember that that action plan achievement rating and reporting is helpful. For anyone who's familiar with the Canadian Occupational Performance Measure people out there, that's a nice kind of way to get that achievement rating. So you ask them like, "What's important to you? How well are you performing this task right now?" And they'll say, "I'm doing about 50%." And then you say, "How satisfied are you with that?" They

	say, "It's terrible." But then you get the person who it's important to them to brush their hair but, for the last five years, they've had shoulder problems and someone's been helping them. So their performance is very poor but they're very satisfied with the fact that their life is okay. So you can use those kind of tools to help you tease out which things are most important to people. Right on time.
ANNOUNCER: 32:41	[music] For more information about Kessler Foundation, go to kesslerfoundation.org. Follow us on Facebook, Twitter, and Instagram. Listen to us on Apple Podcasts, Spotify, SoundCloud or wherever you get your podcasts. [music]