Person-Centered Outcomes Approach
TOOLKIT

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ACKNOWLEDGEMENTS

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1100 13th Street NW | Third Floor | Washington, DC 20005

For more information, contact NCQA via My NCQA.

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CONSULTANTS

NCQA thanks the following individuals for their contributions as subject matter experts in the fields of goal-directed care:

Dr. Lee A. Jennings, MD, MSHS

Associate Professor and Chief
Reynolds Section of Geriatric and Palliative Medicine, Department of Medicine, University of Oklahoma Health Sciences Center

Dr. Lilian Dindo, Ph.D.

Associate Professor
Department of Medicine, Section of Health Services Research, Baylor College of Medicine

Research Health Scientist
Michael E. DeBakey Veterans Affairs Medical Center

PATIENT PARTNERS

We would also like to thank our patient partners who have provided valuable feedback, patient perspectives and experience around person-centered outcomes:

- **Lupe Davila**
- **Ireland Hawkins**
- **Sherry Nolen**
- **David White**

PATIENT PRIORITIES CARE TEAM

Mary Tinetti, MD

Gladys Phillips Crofoot Professor of Medicine and Public Health and Chief of Geriatrics at Yale School of Medicine.

Aanand Naik, MD

Professor, University of Texas Houston

Investigator, Houston Center for Innovations in Quality, Effectiveness and Safety

Michael E. DeBakey VA Medical Center

Jessica Esterson, MPH

Project Director, Patient Priorities Care, Yale University School of Medicine

Tracey Rosen, MSPH

Senior Research Coordinator, Baylor College of Medicine
Curriculum Manager, VA Quality Scholars

Kizzy Hernandez-Bigos

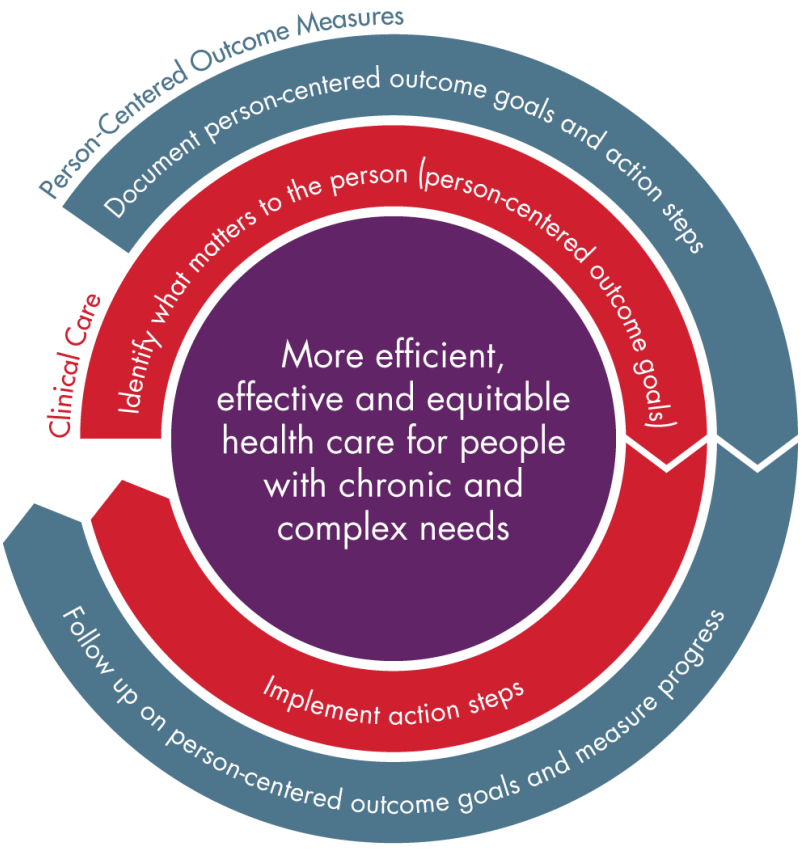
Research Associate, Yale University
Human Services and SDOH Consultant, CT Area Healht Education, Program Office

THE PERSON-CENTERED OUTCOMES APPROACH TOOLKIT

There is broad agreement that individuals' priorities and health goals should guide their care, especially among adults with complex needs who face trade-offs in determining the right course of treatment. The National Committee for Quality Assurance (NCQA) joined forces with individuals and families, research experts, and care organizations, with support from The John A. Hartford Foundation (JAHF) and The SCAN Foundation (TSF) to develop the person-centered outcomes approach and measures to improve and incentivize care for the large and growing group of people with complex health status by capturing and measuring outcomes that matter to them.

Implementation of the person-centered outcomes approach requires multi-stage practice change, including training team members on the approach, adapting workflows and using quality improvement methods to achieve practice change and develop documentation structures. This toolkit is designed to support the implementation of the person-centered outcomes approach in organizations that care for people with complex health status. Each module outlines the steps needed to implement the person-centered outcomes approach successfully.

- **Module 1** introduces the person-centered outcomes approach and measures.
- **Module 2** summarizes the goal setting process and how clinicians can identify what matters most to an individual through a values conversation.
- **Module 3** describes the goal attainment scaling method and how clinicians can use goal attainment scaling to track progress on a goal identified as most important to an individual.
- **Module 4** provides background on Patient-Reported Outcome Measures (PROMs), the second method for tracking goal progress, and how clinicians can use PROMs to assess if an individual is progressing on their identified goals.
- **Each module** has a resource section that contains forms and resources to support implementation of the person-centered outcomes approach.



TOOLKIT

MODULE 1:
The Person-Centered Outcomes Approach

In this module, you will learn:

- The person-centered outcomes approach.
- The steps for implementing person-centered outcome goals.
- The person-centered outcomes measures.

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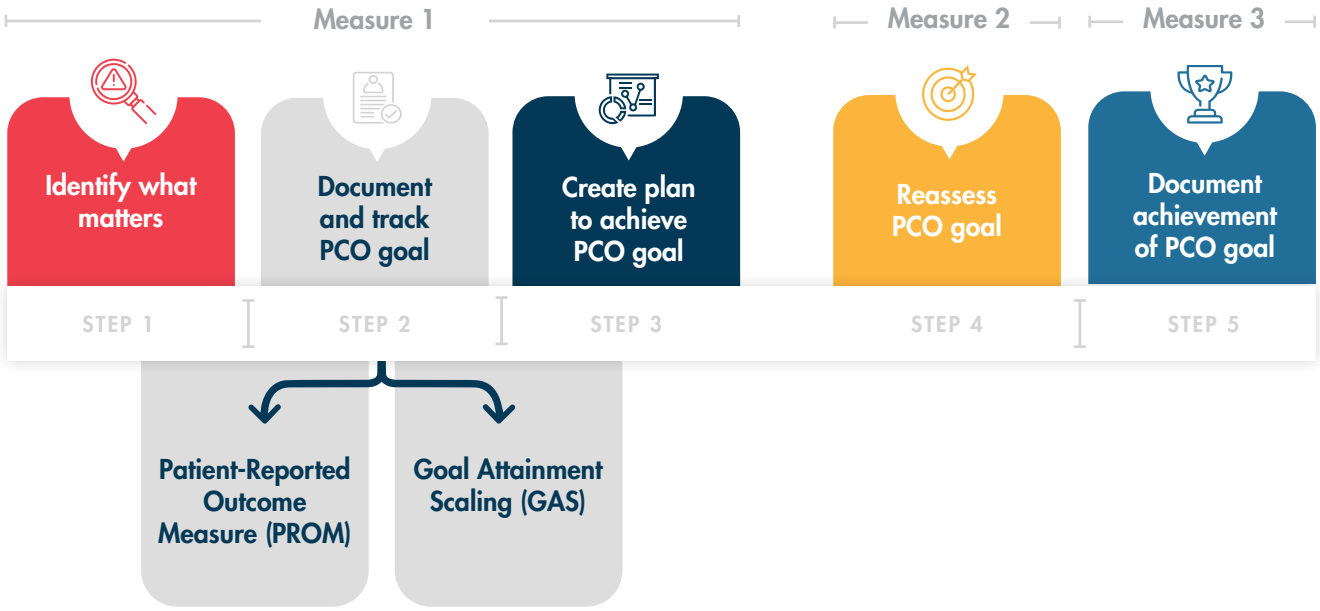
The person-centered outcomes (PCO) approach is an iterative, incremental process for goal-based care. The steps outlined below represent its general framework. An important component of the PCO approach is measurability. A measurable outcome ensures that an individual can identify progress toward achieving a goal.



STEP 1:

Identify what matters.

The clinician and the individual (and/or care partner) talk about the individual's values and collaborate on what matters most to the individual.

STEP 2:

Document and track the PCO goal.

The clinician and individual (and/or care partner) choose one of two approaches—goal attainment scaling (GAS) or a patient-reported outcome measure (PROM)—to document and track the goal.

- **GAS (Module 3):** The individual and clinician define what it means to achieve the goal, using a continuum of five possible outcomes: worse, current state, realistic goal, stretch goal and super stretch goal. They use this scale to monitor the goal over time to see if the individual is improving on the outcome identified as most important.

- **PROMs (Module 4):** Standardized questionnaires that allow individuals to report on how they function or feel with respect to their health, quality of life, mental well-being or health care experience. PROMs generate a score that can be used to monitor change over time.[1] The individual and clinician identify a PROM from a bank of potential PROMs and review the score over time to see if the individual is improving.

[1] Lavallee, D.C., Chenok, K. E., Love, R. M., Petersen, C., Holve, E., Segal, C. D., Franklin, P.D. (2016). Incorporating patient-reported outcomes into health care to engage patients and enhance care. Health Affairs, 35(4):575-582

STEP 3:

Create a plan to achieve the PCO goal.

Once a goal is set, the clinician works with the individual to develop a plan to achieve it, including steps the individual, care partner and/or clinician must take. Creating a plan helps the individual understand what steps need to be taken to achieve the goal.

STEP 4:

Reassess the PCO goal.

After a defined period, the clinician and the individual jointly reassess progress on the goal, using either GAS or by readministering the original PROM, to determine if the individual is on track. This is also an opportunity to revise a goal, if necessary. Reassessing progress is an opportunity for continual appraisal and feedback that can be adapted throughout an individual's care.

STEP 5:

Document and assess achievement of PCO goal.

Goal achievement is the expected outcome of the PCO approach. If GAS is used to document and track the goal, it is achieved if both the individual *and* the clinician score progress at a 0 or above. If PROMs are used, there must be meaningful change between the baseline and follow-up scores to achieve the goal. *(Refer to Module 3: Goal Attainment Scaling and Module 4: Patient-Reported Outcome Measures for details on assessing goal achievement.)*

The whole point of my goal was to be able to get out and be more physically active, to the point where it doesn't feel like a chore anymore.

I'm not struggling to get out and be functional. And it's amazing. Because going from not being able to do anything at all, to slowly starting to feel like my old self again, is kind of a miracle. I was able to play with my nieces and I was actually able to keep up. I feel better.

Individual—38-year-old, White, non-Hispanic female

THE PERSON-CENTERED OUTCOME MEASURES

NCQA developed three measures for assessing an organization's implementation of the PCO approach. Measures are designed to help organizations evaluate how well they help individuals and their care partners identify and achieve what matters most to them.

Goal Identification:
Percentage of individuals 18 years of age and older with a complex care need who had a PCO goal identified, resulting in completion of GAS or a PROM and development of an action plan.

Goal Follow-Up:
Percentage of individuals 18 years of age and older with a complex care need who received follow-up on their PCO goal within two weeks to six months of when the goal and GAS or PROM were identified.

Goal Achievement:
Percentage of individuals 18 years of age and older with a complex care need who achieved their PCO goal within two weeks to six months of when the goal and GAS or PROM were identified.

EXPERIENCE WITH THE PERSON-CENTERED OUTCOMES APPROACH

Although most individuals with complex care needs and clinicians have positive experiences using the PCO approach, it requires changes in workflow and practices. These modules incorporate best practices learned through testing, as well as observed challenges.

The MAIN BENEFITS observed were:

- **Individual and care partner engagement in care.** Individuals and care partners appreciate being asked what matters most to them; for some, it was the first time a health care professional had ever asked. Individuals mentioned that the approach offers accountability for their progress toward reaching a goal.

- **Improved quality of care discussions.** Many clinicians feel the PCO approach improves the quality of care they provide. Some clinicians find the PCO approach is more person-centered than standardized assessments because it starts with what matters most to the individual and helps the clinician better tailor their care to the individuals identified needs.

Through his own efforts, the man lost 18 pounds in the process of this project. It helped to put his goal and plan within a structure. He took his goal and ran with it, which is why this is extremely valuable, because so much of medical care is reactive—responding to an indicator of how you're unhealthy versus promoting a healthy practice. Now he believes that he can do something about his health.

Something very inspiring about this work and something also very surprising is that we don't ask patients, "What's something that's really important that we can do that's positive, proactive; something that's important to you?" And that's when there's a win for the patient and a win for the medical provider.

Clinician—Home-based medical group

TOOLKIT

MODULE 2:
Getting Started With Goal Setting

In this module, you will learn:

- How to identify what matters most through a values discussion.
- Common types of goals.
- How to develop a SMART goal.
- How to support goal achievement.

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OVERVIEW AND IMPORTANCE OF GOALS IN CARE

Individuals and clinicians might not be used to discussing goals during visits. Many individuals expect their clinician to tell them what they need to do for their health or current needs. Sometimes they say what they think the clinician wants to hear: "I know I should lose some weight" or "I really need to quit smoking." This type of goal might reflect what an individual thinks is important ***for*** them, but not what is important **to** them. The person-centered outcomes (PCO) approach gives individuals the chance to think about something they want to achieve.

Goals—clinical and nonclinical—are highly personal. Each individual has unique values and motivators. To help an individual reach their goal, a clinician must first understand what is most important to the individual. Use the following steps to help guide a discussion about goals.

I don't think you're going to improve unless you have goals, and then you have to work up to those goals. For instance, you've got to do your exercises, 10 repetitions or 20 repetitions, and then you try to increase them, and that's the only way you're going to get better.

Individual—89-year-old, White Non-Hispanic, male

IDENTIFY WHAT MATTERS MOST

Values Discussion

First, get to know an individual through a values discussion. Values are the things that really matter to an individual. They help clarify and articulate what matters most in life, and how our actions are in service to those values. Identifying values creates a sense of meaning and purpose in this process. Understanding an individual's history and current circumstances can help guide them through this conversation and to a goal they want to focus on. For example, family, relationships, social activities and physical and mental well-being give meaning and purpose.

This conversation is easier when there is an established relationship—for example, during a second or third encounter—and is most successful when the individual trusts the clinician. Once trust is established, people tend to be more open to discussing their values and objectives. Using motivational interviewing techniques to understand why a goal is important to an individual and acknowledging that the individual is the expert about what is important to them, can also support the conversation.

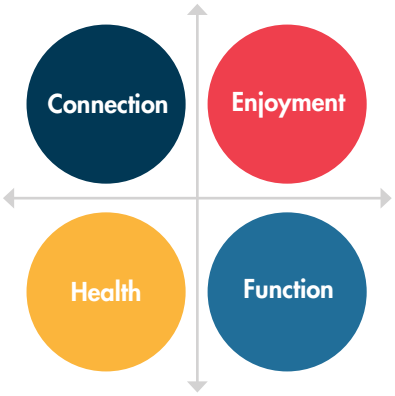
For some clinicians, clarifying values might be unfamiliar or difficult to include in their current workflow.
(Refer to Table 1 and Resources 1-7: Person-Centered Outcomes Approach – Goal Conversation Starters for suggestions.)

Table 1. Conversation starters to help clarify values

"What does a good day look like? What does a bad day look like? What needs to be in place for you to have a good day?"
"What does it mean to you, to say you're 'doing well'? When did you last feel this way?"
"Is there anything in your life you'd like to change that could help you get closer to doing well? In terms of your health, socially or in other ways?"
"In our care visits, you're used to me telling you what to do, but maybe it's time for me to listen to what you want/need. What are your goals?"
"What is most important to you in your life right now? What brings you joy?"
"What would you attempt if thoughts of failure didn't deter you?"
"How would you act differently if X (e.g., symptom/condition) were no longer an obstacle?"
"What projects or activities would you start if your time and energy weren't consumed by X?"
"What relationships would you build or want to build and with whom if X wasn't an issue?"
"What are the actions you take on an ongoing basis in service of?"
"If you no longer struggled with X, how would your life be different? What would you be doing?"

Value Domains

There are generally four value domains[1] 1.) Connection—family, relationships, community, religion; 2.) Enjoyment—personal growth, hobbies, recreational activities; 3.) Health—symptom and health diagnosis management, quality of life; and 4.) Function—independence, being able to live at home, dignity. To understand what matters most to an individual, it's important to understand the value domain most important to them, or the value they want to focus on. What domain impacts their daily life? Do they value one domain over another? This will help narrow the focus and get closer to creating a goal.



Going From a Value to a Goal

What's the difference between a value and a goal? A **value** is the anchor for a goal. Values help an individual focus on what matters most to them. The goal may need to change, depending on an individual's current health, function or life circumstances, but values will likely stay the same. A **goal** is an action that reflects an individual living their values, or aspects of them, at a point in time. Unlike a value, a goal can be achieved.

During value conversations and goal selecting, it's important ***to*** identify what is important to the individual versus what is important ***for*** them. The clinician's ideas and goals for the individual to achieve can be shared but are not the focus of these conversations. The focus should be on identifying what motivates the individual every day. Why do they want what they want? Why do they do what they do? The clinician must understand an individual's abilities, needs and supports, as well as what they expect from their care team. This is the first step in developing a trusting relationship with the individual.

Goal Domains

Based on extensive review of goals developed by individuals and care partners, it has been found that goals typically fall into 12 domains. The list in Table 2 can be used to help an individual and/or their care partner identify the goal they would like to work towards. It is beneficial to track goal domains to help understand the type of goals that are being set in a population as well as to identify that a goal conversation has been completed. *(Refer to Resource 8: Goal Domain Definitions and Examples for additional detail.)*

Table 2. Goal Domains

Housing	Access to Services & Supports	Caregiver Needs & Concerns	End of Life
Independence	Legal	Managing Conditions & Symptoms	Medication Management
Improving Health & Wellness	Physical Function	Social & Role Functioning	Emotional & Mental Health

Goal Inventory

Identifying a goal based on a value may take time. Sometimes the word "goal" doesn't resonate with an individual, so having concrete examples can help them think of options and potential goals to work on. A "goal inventory"—a list of suggested goals—can support this conversation. Goal inventories are available **for individuals, care partners and with a focus on behavioral health. All goal inventories are available in multiple languages**. *(Refer to Resources 9 – 29 for the goal inventories.)*

[1] Jamieson, K., Ogedengbe, O., Naik, A. D., Kiefer, L., Tak, C., Atkins, C., & Woodall, T. (2024). Implementation of patient priorities-aligned care in a home-based primary care program. Journal of the American Pharmacists Association : JAPhA, 64(1), 96–103. https://doi.org/10.1016/j.japh.2023.10.027

COMMON GOAL TYPES

Clinical recommendations may sometimes differ from an individual's goals, or an individual's goals may seem unrealistic. Clinicians can help individuals identify goals that are safe and attainable with available resources, making sure their voice is heard.

Process vs. outcome goals

Goals can address processes or outcomes. For example, if an individual's goal is to reduce the number of times they fall, this can be operationalized as an outcome (the number of falls) or as a process (removing fall risk hazards in the home; attending an exercise program to improve balance). It's best to avoid combining outcomes and processes in the same goal.

Individual- vs. clinician-actionable goals

Some individuals want to engage in an activity that the clinician can influence; for example, by arranging transportation or a referral for a service such as physical therapy. These goals focus on achievement (e.g., being willing to leave the house, showing up for appointments on time).

Using language that continues the conversation ("Why is this goal important to you?"; "Does this goal capture what matters to you?") can lead an individual from a clinician-actionable goal (ex. control blood pressure with medication) to an individual-actionable goal (ex. walk around the block once a week). If the individual and clinician work together, a larger, clinician-actionable goal can be broken into smaller, individual- actionable goals that are both more meaningful to the individual as well as in the individual's control.

Unrealistic goals

At times, an individual's desires or priorities may not be immediately attainable—or attainable at all—or may differ from those of family, care partners or clinicians. For example, someone with dementia wants to drive, or someone who uses a wheelchair due to advanced frailty wants to walk unassisted. Individuals might not understand how a new diagnosis or a recent change in prognosis will affect their goals. This can be addressed by discussing expectations and setting realistic goals, focusing on what is important; perhaps saying, "I want to set you up for success." A clinician who respects and accepts an individual's goal without judgment can suggest changes that are likely to be interpreted as supportive and person-centered. Explore why the original goal is important (e.g., "Being able to walk would let me be more independent/relieve burden on my care partner") and identify a goal that relates to that issue or need.

If an individual still wants to set an unrealistic goal after this conversation, the request can be honored and a note made to review expectations at a follow-up meeting.

SETTING SMART GOALS

Goals may be documented in the individual's words or paraphrased by the clinician. Using an individual's own words when documenting goals can help ensure that the goals truly reflect what matters most to the individual, but may make it more difficult to measure progress if key elements for a measurable goal are missing. To balance the need for accuracy in understanding what's most important to the individual and the need to measure progress on the goal, clinicians can help an individual recast ideas and concepts into the SMART format (Specific, Measurable, Attainable, Relevant, Time-Bound). Research has shown that when goals are SMART, individuals are more likely to achieve them.

Specific

Individuals sometimes start with broad goals that can be refined into more specific goals that are measurable and attainable. Setting goals about general states of health or well-being, such as "I want to feel better" or "I want to be in better health," should be avoided, if possible, since these may be difficult to measure and attain. Asking the individual, "What does being in better health look like?" or "What does 'feel better' mean to you?" is a good way to elicit specific goals. Its important the goal is specific to just one thing or topic. If a goal has multiple parts, how would you rate progress if the individual is successful for one part of the goal but not the other?

Measurable

When a goal is measurable, it ensures that the goal has some benchmark to monitor progress that includes either a quantity or operationalized behavior. This allows for both you and the individual to have the same definition of success and clearly defines how the goal will be accomplished. Some examples include distance walked in steps, blocks or miles, a certain amount of money saved, the frequency in which some activity is conducted or the number of pounds for weight loss or gain. Asking probing questions to understand how the individual will mark the achievement of their goal can help to quantify the goal.

Attainable

Some individuals will identify unrealistic goals, and might not want to change to a more fitting goal. Their perspective and perception of what is attainable may be different from the clinician. Be prepared to discuss and negotiate this mismatch.

Relevant

The goal should reflect something that is ***important and relevant*** to the individual's life. Sometimes an individual doesn't have a specific goal other than to keep living the way they are currently living. Ask what they like about how things are now and use this status as the *expected* outcome.

Time-bound

Some individuals like to set short-term goals; others focus on the long term. Create goals that can be followed up on based on the cadence of visits. Goals should be able to be completed in 6 months or less. If a goal will take longer to achieve, consider how it can be broken into smaller pieces. For example, "How will you know by our next visit if you are making progress toward your longer-term goal?"

COMMON DIFFICULTIES WITH GOAL SETTING

- **Changing goals.** An individual who has chosen a primary goal might articulate a different goal. This might be because they are still defining what is most important to them. Be patient with the process.
- **The goal has too many parts.** Sometimes individuals have difficulty focusing on one goal. If there are too many parts to a goal, it may be difficult to measure achievement if one part is met but another is not. Consider splitting complicated goals into two or more simpler goals, and let the individual choose one goal to reach first.
- **Goals are specific to the care partner.** Individuals might feel guilty choosing care partner-specific goals. Assure the individual that it's okay to have goals that focus on care partners. There are options for setting care partner goals; for example, the care partner and the individual choose a goal for the individual to work on; the care partner is the individual's proxy and sets the goal for them; the care partner sets a goal for themselves. *(Refer to Resource 23-29 for examples of goals for care partners.)*

SUPPORTING GOAL ACHIEVEMENT

Once goals are established, clinicians can help individuals sustain motivation and the desire for change by discussing how progress will be measured. Identifying facilitators and barriers to goals can inform changes to the care plan. Reaching goals can be a challenging process, yet rewarding when the individual is working toward what matters most to them.

Support goal achievement

- Identify and address potential barriers to achieving a goal. For example, if the goal is "Walk three times a week," ask if there are alternative places to walk in bad weather.
- Set expectations and assign responsibilities to support plans to achieve a goal. If an individual needs physical therapy to strengthen their legs, for example, ensure that they understand that a plan to engage a physical therapist is part of the goal.
- Identify how to measure improvement or success. Individuals may set a process goal that is too broad or takes too long to reach, but can be broken up into smaller, actionable steps. Discussing this as the goal is set may prevent disappointment or lack of achievement later.

Review and update goals

- Regularly review goals, including progress and barriers. Ensure that there is a visit schedule or a means of communication that allows adequate support and provides time for discussing progress. Regardless of when visits are held, it's a good idea to establish clear expectations about what will be reviewed.
  - "By the next time we meet, you will be walking one mile every other day."
  - "I'm going to check in with you every 4 weeks to see how you are doing on your goals."
- Documenting conversations about goals in the individual's health record is essential to follow-up and to managing progress.
- Retire or modify goals once they have been achieved or are no longer desired. An individual's priorities or health concerns may change over time. Focusing on what matters to the individual should drive the goal-setting process.

I think that the person-centered outcomes approach helped us make sure we're having the conversation about goal setting. We thought we were doing this all the time, but we weren't really doing it as frequently, as consistently, as we thought we were. I think it also helps us raise the definition of person-centered care. A lot of people purport that they do person-centered care, and we also have been saying that for a very long time, but this has brought a little more discipline to that conversation.

Administrator—Geriatric primary care setting

RESOURCE 1:

Person-Centered Outcomes Approach—Goal Conversation Starters—English

Identifying the Value

It's important to discuss an individual's values, and transition from values to goals. Start the process with a conversation about what values matter most to the individual. This helps identify an actual goal to work toward. Use this conversation to better understand the primary goal on which the individual wants to focus.

It may help to first assess the value domain (connection, enjoyment, health, function) that is most important to the individual by asking, "On a scale of 0 to 10, where 0 is not important at all and 10 is extremely important, how important is connection/enjoyment/health/function?"

Below is a list of conversation starters about values (depending on the individual).

- How would you act differently if X (e.g., depression, anxiety, pain, health condition) were no longer an obstacle?
- What projects or activities would you start if your time and energy weren't consumed by X (e.g., depression, anxiety, pain, health condition)?
- What would you do if X (e.g., condition) were no longer an issue?
- What would you attempt if thoughts of failure didn't deter you?
- What sort of relationships would you build, and with whom?
- What changes would you make in your work?
- If you no longer struggled with X, how would your life be different? What would you be doing?
- What's the worst thing for you about being X?
- What in life is so important to you that you would be willing to experience difficulty/pain to get it?

Identifying the Goal

Below are conversation starters to use when identifying an individual's goals. They are derived from the experience of clinicians and individuals who participated in the PCO approach.

- "What does a good day look like? What does a bad day look like? What needs to be in place for you to have a good day?"
- "What does it mean to you, to say you're 'doing well'? When did you last feel this way?"
- "As my patient, you're used to me telling you what to do, but maybe it's time for me to listen to you and what you want/need. What are your goals?"
- "We're trying to make health care more person-centered. We want to help you achieve these goals. We will do this exercise to help you plot a plan and achieve this goal."
- "I want to hear your goals rather than tell you what to do…"
- "We want to find out what is the most important goal to you. How can we make things better? We're going to focus on your top goal, what's important, and how you are going to achieve it."
- "These are your top goals, and we want to see how we can make your top goal better…"
- "I'm thinking along the lines of… would you agree or disagree?"
- "Is that appropriate?"
- "Am I completely off, or wrong?"
- "Is that reasonable?"

RESOURCE 2:

Person-Centered Outcomes Approach—Goal Conversation Starters—Arabic

Identifying the Value

You first start the process with having a conversation about what values matter most to the individual. Starting with values helps place the goal in a context that can be used to identify an actual goal to work towards. You will use this conversation to better understand the one goal the individual will want to focus on. It is important to discuss an individual's values and then transition from values to goals.

It may be helpful to first assess which value domain (connection, enjoyment, health, function) is most important to the individual by asking "how important on a scale of 0 to 10 where zero is not important at all and ten is extremely important is connection, enjoyment, health, and function?"

Below is a list of conversation starters you may want to use to start the discussion around values depending on the individual.

- إلى أي حد سيختلف تصرفك إذا لم يعد X (مثل الاكتئاب والقلق والألم والحالة الصحية) يُشكل أمامك عائقًا؟
- ما هي المشاريع أو الأنشطة التي كنت ستشرع في أدائها إذا لم يستنفد X (مثل الاكتئاب والقلق والألم والحالة الصحية) وقتك وطاقتك؟
- ماذا كنت ستفعل إذا لم تعد X (على سبيل المثال، الحالة المرضية) تُمثل مشكلة؟
- ما الذي كنت ستحاول فعله إذا لم تردعك أفكار الخوف من الفشل؟
- ما نوع العلاقات التي كنت ستنشئها ومع من؟
- ما هي التغييرات التي كنت ستجريها في عملك؟
- إلى أي مدى كانت ستتغير حياتك إذا لم يعد X يُشكل عائقًا لك؟ ماذا كنت ستفعل؟
- ما أسوأ شيء بالنسبة لك بشأن إصابتك بـ X؟
- ما هو أهم شيء بالنسبة لك في الحياة والذي يجعلك على استعداد لتحمل المصاعب/الألم لكي تحصل عليه؟

Identifying a Goal

Below are conversation starters that you may want to use when identifying goals from individuals. These are derived from the experience of clinicians and individuals who participated in the person-centered outcome approach.

- "ما هو اليوم الرائع من وجهة نظرك؟ ما هو اليوم السيء من وجهة نظرك؟ ما الذي يتعين توافره لكي يكون يومك جيدًا؟"
- "ما الشروط الواجب توافرها لتقول إنك "على ما يُرام"؟" متى شعرت بهذا الشعور آخر مرة؟"
- "باعتبارك مريضًا لدي، فلقد اعتدت على أن أخبرك بما يجب عليك فعله، ولكن ربما قد حان الوقت لأستمع إليك وإلى ما تريده/تحتاجه. ما هي أهدافك؟"
- "نحاول أن نجعل الرعاية الصحية مرتكزة على الشخص بدرجة أكبر. نريد أن نساعدك على تحقيق هذه الأهداف. وسنؤدي هذا التمرين لمساعدتك على وضع خطة وتحقيق هذا الهدف".
- "أريد أن أستمع لأهدافك، لا أن أخبرك بما يتعين عليك فعله..."
- "نريد أن نعرف الهدف الأهم بالنسبة لك. كيف يمكننا تحسين الأمور؟ سنركز على هدفك الأهم، وما هو مهم، وكيف ستحققه".
- "هذه هي أهم أهدافك ونريد أن نتوصل إلى طريقة يمكن من خلالها تحسين هدفك الأهم..."
- "أفكر بطريقة...هل توافق أم لا توافق؟"
- "هل هذا مناسب؟"
- "هل أنا مخطئ تمامًا أو أخطأت الفهم؟"
- "هل هذا معقول؟"

RESOURCE 3:

Person-Centered Outcomes Approach—Goal Conversation Starters—Russian

Identifying the Value

You first start the process with having a conversation about what values matter most to the individual. Starting with values helps place the goal in a context that can be used to identify an actual goal to work towards. You will use this conversation to better understand the one goal the individual will want to focus on. It is important to discuss an individual's values and then transition from values to goals.

It may be helpful to first assess which value domain (connection, enjoyment, health, function) is most important to the individual by asking "how important on a scale of 0 to 10 where zero is not important at all and ten is extremely important is connection, enjoyment, health, and function?"

Below is a list of conversation starters you may want to use to start the discussion around values depending on the individual.

- Как иначе бы вы себя вели, если бы состояние X (например, депрессия, тревога, боль, проблемы со здоровьем) больше не представляло препятствие?
- К каким проектам или занятиям вы бы приступили, если бы ваше время и энергия не поглощались состоянием X (например, депрессией, тревогой, болью, проблемами со здоровьем)?
- Что бы вы сделали, если бы состояние X (например, проблемы со здоровьем) больше вас не беспокоило?
- Что бы вы попытались сделать, если бы мысли о неудаче не останавливали вас?
- Какие отношения вы бы построили и с кем?
- Что бы вы изменили в своей работе?
- Если бы вы больше не боролись с состоянием X, как бы изменилась ваша жизнь? Чем бы вы занимались?
- Что для вас самое худшее в жизни с состоянием X?
- Что в жизни настолько важно для вас, что вы готовы испытывать трудности/боль, чтобы добиться этого?

Identifying a Goal

Below are conversation starters that you may want to use when identifying goals from individuals. These are derived from the experience of clinicians and individuals who participated in the person-centered outcome approach.

- «Каким вы представляете хороший день? Каким вы представляете плохой день? Что нужно для того, чтобы у вас был хороший день?»
- «Что для вас значит сказать, что у вас „все хорошо"? Когда вы в последний раз так себя чувствовали?»
- «Как мой пациент, вы привыкли к тому, что я говорю вам, что делать, но, возможно, пришло время выслушать вас и узнать, чего вы хотите и в чем нуждаетесь. Каковы ваши цели?»
- «Мы стремимся сделать медицинское обслуживание более персонализированным. Мы хотим помочь вам дост этих целей. Мы выполним это упражнение, чтобы помочь вам разработать план и достичь этой цели».
- «Я хочу узнать ваши цели, а не говорить вам, что делать…»
- «Мы хотим выяснить, что для вас является самой важной целью. Как мы можем исправить ситуацию? Мы сосредоточимся на вашей главной цели, на том, что для вас важно, и на том, как вам достичь желаемого».
- «Это ваши главные цели, и мы хотим понять, как можно их улучшить…»
- «Я мыслю в таком ключе... Вы согласны или нет?»
- «Уместно ли это?»
- «Я совсем промахнулся и ошибаюсь?»
- «Находите ли вы это целесообразным?»

RESOURCE 4:

Person-Centered Outcomes Approach—Goal Conversation Starters —Simplified Chinese

Identifying the Value

You first start the process with having a conversation about what values matter most to the individual. Starting with values helps place the goal in a context that can be used to identify an actual goal to work towards. You will use this conversation to better understand the one goal the individual will want to focus on. It is important to discuss an individual's values and then transition from values to goals.

It may be helpful to first assess which value domain (connection, enjoyment, health, function) is most important to the individual by asking "how important on a scale of 0 to 10 where zero is not important at all and ten is extremely important is connection, enjoyment, health, and function?"

Below is a list of conversation starters you may want to use to start the discussion around values depending on the individual.

- 如果X（例如，抑郁、焦虑、疼痛、健康状况）不再成为您的一个障碍，您会采取怎样不同的行动？
- 如果您的时间和精力没有被X（例如，抑郁、焦虑、疼痛、健康状况）消耗掉，您会进行哪些项目或者活动？
- 如果X（例如，某状况）不再是一个问题，您会做些什么？
- 如果失败的念头没有让您退缩，您会尝试些什么？
- 您会建立什么样的关系，与谁建立这些关系？
- 在工作中您会做出哪些改变？
- 如果您不再纠结于X，您的生活会有何不同？您现在会在做些什么？
- 对您来说，患有X最糟糕的事情是什么？
- 生活中有什么对您来说非常重要，以至于您愿意经历困难/痛苦去获得它？

Identifying a Goal

Below are conversation starters that you may want to use when identifying goals from individuals. These are derived from the experience of clinicians and individuals who participated in the person-centered outcome approach.

- "美好的一天是什么样的？糟糕的一天是什么样的？对您来说，拥有美好的一天需要具备什么条件？"
- "说自己'做得很好'，对您来说意味着什么？您最后一次有这种感觉是什么时候？"
- "作为我的患者，您已经习惯了我告诉您该怎么做，但也许是时候让我倾听您的心声，听听您想要些什么/需要些什么了。您的目标是什么？"
- "我们正努力使医疗护理更加以人为本。我们想帮助您实现这些目标。我们将通过这个练习来帮助您制定一个计划并实现这个目标。"
- "我想听听您的目标，而不是告诉您去做什么……"
- "我们想知道对您来说最重要的目标是什么。我们怎样才能让情况变得更好？我们将重点关注您的首要目标、重要事项以及如何实现目标。"
- "这些是您的首要目标，我们希望了解如何才能更好地实现您的首要目标……"
- "我的思考方向是……您同意还是不同意？"
- "这样合适吗？"
- "我完全偏离或者错了吗？"
- "这样合理吗？"

RESOURCE 5:

Person-Centered Outcomes Approach—Goal Conversation Starters—Spanish

Identifying the Value

You first start the process with having a conversation about what values matter most to the individual. Starting with values helps place the goal in a context that can be used to identify an actual goal to work towards. You will use this conversation to better understand the one goal the individual will want to focus on. It is important to discuss an individual's values and then transition from values to goals.

It may be helpful to first assess which value domain (connection, enjoyment, health, function) is most important to the individual by asking "how important on a scale of 0 to 10 where zero is not important at all and ten is extremely important is connection, enjoyment, health, and function?"

Below is a list of conversation starters you may want to use to start the discussion around values depending on the individual.

- ¿Cómo actuaría de forma diferente si X (por ejemplo, la depresión, ansiedad, dolor, estado de salud) dejara de ser un obstáculo?
- ¿Qué proyectos o actividades iniciaría si su tiempo y energía no estuvieran consumidos por X (por ejemplo, la depresión, la ansiedad, el dolor, la enfermedad)?
- ¿Qué haría si X (por ejemplo, la enfermedad) dejara de ser un problema?
- ¿Qué intentaría si no le disuadieran los pensamientos de fracaso?
- ¿Qué tipo de relaciones entablaría y con quién?
- ¿Qué cambios haría en su trabajo?
- Si ya no tuviera problemas con X, ¿en qué cambiaría su vida? ¿Qué haría?
- ¿Qué es lo peor para usted de ser X?
- ¿Qué es tan importante para usted en la vida que estaría dispuesto/a a experimentar dificultades o dolores para conseguirlo?

Identifying a Goal

Below are conversation starters that you may want to use when identifying goals from individuals. These are derived from the experience of clinicians and individuals who participated in the person-centered outcome approach.

- "¿Cómo es un buen día? ¿Cómo es un mal día? ¿Qué tiene que suceder para que tenga un buen día?".
- "¿Qué significa para usted decir que le va bien? ¿Cuándo se sintió así por última vez?".
- "Como paciente mío, está acostumbrado a que le diga lo que tiene que hacer, pero quizá ha llegado el momento de escucharle y saber lo que quiere o necesita. ¿Cuáles son sus objetivos?"
- "Estamos intentando que la atención médica se centre más en las personas. Queremos ayudarle a conseguir estos objetivos. Haremos este ejercicio para ayudarle a trazar un plan y alcanzar este objetivo".
- "Quiero escuchar sus objetivos en lugar de decirle lo que tiene que hacer".
- "Queremos saber cuál es el objetivo más importante para usted. ¿Cómo podemos mejorar las cosas? Vamos a centrarnos en su objetivo principal, en lo que es importante y en cómo conseguirlo".
- "Estos son sus objetivos principales y queremos ver cómo podemos mejorar su objetivo principal".
- "Estoy pensando en algo como... ¿está de acuerdo o en desacuerdo?".
- "¿Le parece apropiado?".
- "¿Estoy completamente equivocado?".
- "¿Le parece razonable?".

RESOURCE 6:

Person-Centered Outcomes Approach—Goal Conversation Starters —Traditional Chinese

Identifying the Value

You first start the process with having a conversation about what values matter most to the individual. Starting with values helps place the goal in a context that can be used to identify an actual goal to work towards. You will use this conversation to better understand the one goal the individual will want to focus on. It is important to discuss an individual's values and then transition from values to goals.

It may be helpful to first assess which value domain (connection, enjoyment, health, function) is most important to the individual by asking "how important on a scale of 0 to 10 where zero is not important at all and ten is extremely important is connection, enjoyment, health, and function?"

Below is a list of conversation starters you may want to use to start the discussion around values depending on the individual.

- 如果X（例如，抑鬱、焦慮、疼痛、健康狀況）不再成為您的一個障礙，您會採取怎樣不同的行動？
- 如果您的時間和精力沒有被X（例如，抑鬱、焦慮、疼痛、健康狀況）消耗掉，您會進行哪些項目或者活動？
- 如果X（例如，某狀況）不再是一個問題，您會做些什麼？
- 如果失敗的念頭沒有讓您退縮，您會嘗試些什麼？
- 您會建立什麼樣的關係，與誰建立這些關係？
- 在工作中您會做出哪些改變？
- 如果您不再糾結於X，您的生活會有何不同？您現在會在做些什麼？
- 對您來說，患有X最糟糕的事情是什麼？
- 生活中有什麼對您來說非常重要，以至於您願意經歷困難/痛苦去獲得它？

Identifying a Goal

Below are conversation starters that you may want to use when identifying goals from individuals. These are derived from the experience of clinicians and individuals who participated in the person-centered outcome approach.

- "美好的一天是什麼樣的？糟糕的一天是什麼樣的？對您來說，擁有美好的一天需要具備什麼條件？"
- "說自己'做得很好'，對您來說意味著什麼？您最後一次有這種感覺是什麼時候？"
- "作為我的患者，您已經習慣了我告訴您該怎麼做，但也許是時候讓我傾聽您的心聲，聽聽您想要些什麼/需要些什麼了。您的目標是什麼？"
- "我們正努力使醫療護理更加以人為本。我們想幫助您實現這些目標。我們將通過這個練習來幫助您制定一個計劃並實現這個目標。"
- "我想聽聽您的目標，而不是告訴您去做什麼……"
- "我們想知道對您來說最重要的目標是什麼。我們怎樣才能讓情況變得更好？我們將重點關注您的首要目標、重要事項以及如何實現目標。"
- "這些是您的首要目標，我們希望瞭解如何才能更好地實現您的首要目標……"
- "我的思考方向是……您同意還是不同意？"
- "這樣合適嗎？"
- "我完全偏離或者錯了嗎？"
- "這樣合理嗎？"

RESOURCE 7:

Person-Centered Outcomes Approach—Goal Conversation Starters—Vietnamese

Identifying the Value

You first start the process with having a conversation about what values matter most to the individual. Starting with values helps place the goal in a context that can be used to identify an actual goal to work towards. You will use this conversation to better understand the one goal the individual will want to focus on. It is important to discuss an individual's values and then transition from values to goals.

It may be helpful to first assess which value domain (connection, enjoyment, health, function) is most important to the individual by asking "how important on a scale of 0 to 10 where zero is not important at all and ten is extremely important is connection, enjoyment, health, and function?"

Below is a list of conversation starters you may want to use to start the discussion around values depending on the individual.

- Nếu X (ví dụ: trầm cảm, lo lắng, đau đớn, tình trạng sức khỏe) không còn là trở ngại nữa, bạn sẽ hành động khác đi thế nào?
- Nếu thời gian và năng lượng của bạn không bị X (ví dụ: trầm cảm, lo lắng, đau đớn, tình trạng sức khỏe) choán hết, bạn sẽ bắt đầu những dự án hoặc hoạt động nào?
- Nếu X (ví dụ: tình trạng sức khỏe) không còn là vấn đề nữa, bạn sẽ làm gì?
- Nếu những suy nghĩ về thất bại không làm bạn nản lòng, bạn sẽ thử làm gì?
- Bạn sẽ xây dựng những mối quan hệ nào và với ai?
- Bạn muốn có những thay đổi nào trong công việc của mình?
- Nếu bạn không còn phải vật lộn với X nữa, cuộc sống của bạn sẽ khác như thế nào? Bạn sẽ đang làm gì?
- Đối với bạn, điều tồi tệ nhất khi là/bị X là gì?
- Điều gì trong cuộc sống quan trọng với bạn đến mức bạn sẵn sàng trải qua khó khăn/đau khổ để có được?

Identifying a Goal

Below are conversation starters that you may want to use when identifying goals from individuals. These are derived from the experience of clinicians and individuals who participated in the person-centered outcome approach.

- "Một ngày tốt đẹp là như thế nào? Một ngày tồi tệ là như thế nào? Để bạn có một ngày tốt đẹp, cần có những điều gì?
- "Nói rằng bạn 'đang ổn' nghĩa là gì đối với bạn? Lần cuối cùng bạn cảm thấy vậy là khi nào?"
- "Là bệnh nhân của tôi, bạn đã quen với việc tôi bảo bạn việc cần làm, nhưng có lẽ đã đến lúc tôi lắng nghe bạn và những điều bạn mong muốn/cần. Những mục tiêu của bạn là gì?"
- "Chúng tôi đang nỗ lực để dịch vụ chăm sóc sức khỏe xoay quanh con người nhiều hơn. Chúng tôi muốn giúp bạn đạt được những mục tiêu này. Chúng tôi sẽ thực hiện hoạt động này để giúp bạn lập kế hoạch và đạt được mục tiêu này."
- "Tôi muốn lắng nghe mục tiêu của bạn thay vì bảo bạn việc cần làm…"
- "Chúng tôi muốn tìm hiểu mục tiêu quan trọng nhất đối với bạn là gì. Chúng ta có thể làm thế nào để cải thiện tình hình? Chúng ta sẽ tập trung vào mục tiêu hàng đầu của bạn, điều gì là quan trọng và cách để bạn đạt được mục tiêu đó."
- "Đây là những mục tiêu hàng đầu của bạn và chúng tôi muốn xem làm thế nào để có thể hoàn thiện thêm mục tiêu hàng đầu của bạn…"
- "Tôi đang nghĩ theo hướng…bạn có đồng ý hay không?"
- "Điều đó có phù hợp không?"
- "Tôi có nói chưa chuẩn lắm hay sai không?"
- "Điều đó có hợp lý không?"

RESOURCE 8:
Goal Domain Definitions and Examples for additional detail

Goal Domain Name	Definition	Goal Examples
Housing	Goals related to individuals' place of residence.	• Choice of residence/acceptable housing • Be able to stay in your home for as long as possible • Live in the most integrated setting appropriate to needs • Obtain housing
Access to Services & Supports	Goals focused on the ability to access, afford, and utilize appropriate health and community resources including access to transportation, stable food resources, assistance with financial concerns.	• Access transportation services • Have access to reliable food resources • Apply for and/or receive utility support • Apply for and/or receive financial support • Gain access to adequately trained paid caregivers and community resources
Caregiver Needs & Concerns	Goals expressed by and for caregivers that focus on caregiving responsibilities and skills, finding respite care, and receiving social support.	• Receive respite care • Improve confidence with caregiving
End of Life	Goals related to end-of-life care and desires.	• Manage end-of-life care preferences • Reduce burden on family or others • Get finances in order
Independence	Goals that center on living one's life independently without help or assistance from others.	• Retain or regain independence in daily life • Continue to drive or use transportation • Maintain household and self-care management • Gain employment
Legal	Goals related to legal issues or legal involvement.	• Receive legal support • Prevent recidivism • Manage child custody issues • Designate a legal proxy, guardian, medical power of attorney • Develop an Advanced Care Directive
Managing Conditions & Symptoms	Goals related to health care received or desired and to experiences with providers and the health care system.	• Manage physical symptoms of illness, including pain, sleep, and bodily functions (e.g., incontinence) • Maintain comfort while managing physical symptoms or a chronic condition • Manage multiple providers, medical resources, and finances • Manage mental health symptoms, including depression and anxiety • Manage substance use symptoms, including reducing or eliminating illicit drug/alcohol use

Goal Domain Name	Definition	Goal Examples
Medication Management	Goals focused on the ability to manage medications.	• Eliminate or reduce medication side effects • Reduce the number of medications taken • Understand the purpose of each prescribed medication • Take medication as prescribed • Access needed medication
Improving Health & Wellness	Goals related to developing, improving and maintaining positive health and wellness habits.	• Maintain or improve health and quality of life • Maintain adequate nutrition, quit smoking, exercise and physical activity, and maintain a healthy weight • Maintain or improve sleep hygiene
Physical Function	Goals related to managing physical functioning, physical symptoms or conditions and improving or maintaining the ability to participate in physical activities.	• Improve mobility • Improve or maintain physical health • Increase or maintain physical activity • Perform self-care and household activities • Improve physical safety such as avoiding falling
Social & Role Functioning	Goals focused on engaging in meaningful activity like work, hobbies, or social interaction with family and friends.	• Continue educational studies, including technology training • Attend specific life events, or have everyday outings • Obtain or maintain employment or volunteer opportunities • Maintain positive, healthy connections with life partner, family and friends • Fulfill family role function, including parenting
Emotional & Mental Health	Goals related to managing mental health symptoms or participating in activities that impact emotional aspects of quality of life.	• Maintain a positive affect • Maintain or improve relationships with others, including family members, friends, and romantic partners • Incorporate or maintain religious and spiritual goals in daily life • Participate in activities to decrease and/or manage anxiety, depression, mental health symptoms

RESOURCE 9:
Behavioral Health Goal Inventory—English

Behavioral Health Goal Inventory: What Matters Most

Select a goal you would like to work on with your care team. You can change these goals or write your own.
Mark an "**X**" next to the area that is most the most important to you.

	My Priority
Improve or maintain my mental health (for example, manage depression, grief, anxiety, anger)	
Get specific care or services (for example, medical procedure, join a peer support group, schedule doctor appointment)	
Avoid treatments I don't want when I am in crisis—develop a psychiatric advance directive	
Stay out of the hospital	
Go to the hospital/doctor/therapist when I need to	
Reduce or eliminate substance use	
Manage medications or prescriptions	
Care for myself (for example, dressing, bathing, cooking, shopping, finances)	
Be physically active (for example, walking, swimming, physical or occupational therapy exercises)	
Do recreational activities (for example, hobbies, community events, travel, volunteer)	
Continue to work or volunteer, find a job	
Save up money or get financial support/services	
Spend time with friends and family	
Practice religious or spiritual life	
Pursue educational activities (for example, obtain GED, enroll in college, secure professional accreditation or license)	
Get legal support (for example, assistance with child custody, psychiatric advance directives, other legal services)	
Avoid involvement with the justice system (for example, finish probation, stay out of jail)	
Maintain safety	
Move to a different home, find stable housing (for example, move in with family, find independent housing)	
Receive services and support (for example, enroll for government benefits such as food resources, social service resources, transportation services)	
Receive support in coping with my chronic condition and care needs	
Write your own:	

RESOURCE 10:
Behavioral Health Goal Inventory—Arabic

قائمة أهداف الصحة السلوكية: أهم ما يريده الشخص

اختر هدفًا ترغب في العمل على تحقيقه مع فريق رعايتك. ولك أن تغيّر هذه الأهداف وأن تكتب كذلك هدفًا آخر تنشده. ضع علامة **"X"** أمام الشيء الأهم بالنسبة لك.

	أولوياتي
تحسين صحتي النفسية أو الحفاظ عليها (من الاكتئاب، والحزن، والقلق، والغضب، وغيرها)	
تلقي رعاية أو خدمات محددة (مثل: إجراء طبي محدد، الانضمام إلى إحدى مجموعات دعم الأقران، أو تحديد موعد لزيارة طبيب)	
تجنب العلاج الذي لا أرغب فيه عندما أكون في أزمة - أعتمد على التوجيهات الطبية النفسية المسبقة	
الابتعاد عن المستشفى	
الذهاب إلى المستشفى/الطبيب/المعالج عند الحاجة	
الحد من تناول العقاقير المخدرة أو التوقف عن تناولها	
الالتزام بمواعيد تناول الأدوية أو الوصفات الطبية	
الاعتناء بنفسي (مثلًا ارتداء الملابس، والاستحمام، وطهي الطعام، والتسوق، وأموري المالية)	
التمتع بالنشاط البدني (كممارسة المشي، والسباحة، وتمارين العلاج الطبيعي والوظيفي، مثلًا)	
ممارسة الأنشطة الترفيهية (كالهوايات، أو حضور الفعاليات المجتمعية، أو السفر، أو التطوع)	
مواصلة العمل أو التطوع أو الحصول على وظيفة	
إدخار المال أو الحصول على الدعم/الخدمات المالية	
قضاء مزيد من الوقت مع الأهل والأصدقاء	
ممارسة الشعائر الدينية أو الروحانية	
متابعة الأنشطة التعليمية (على سبيل المثال، اجتياز اختبار تطوير التعليم العام "GED" أو الالتحاق بكلية، أو الحصول على اعتماد أو ترخيص مهني)	
الحصول على دعم قانوني (على سبيل المثال، إعانة في حضانة الأطفال، أو توجيهات مُسبقة للعلاج النفسي، أو خدمات قانونية أخرى)	
تجنب التورط في مسائل قضائية (على سبيل المثال، الانتهاء من فترة المراقبة، وعدم ارتكاب فعل يفضي إلى السجن)	
الحفاظ على السلامة	
الانتقال إلى منزل آخر أو تأسيس مسكن دائم (كالعيش مع الأسرة، أو البحث عن سكن مستقل)	
تلقي الخدمات والدعم (على سبيل المثال، التسجيل للحصول على مزايا حكومية مثل الموارد الغذائية، وموارد الخدمة الاجتماعية، وخدمات النقل)	
تلقي الدعم في التعايش مع مرضي المزمن واحتياجات رعايتي	
اكتب هدفًا آخر تنشده:	

RESOURCE 11:
Behavioral Health Goal Inventory—Russian

Выбор целей для поведенческого здоровья. Что важнее всего?

Выберите цель, над которой вы хотели бы работать вместе со своей командой по уходу. Вы можете изменить эти цели или добавить свои собственные. Поставьте **«X»** напротив наиболее важной для вас сферы.

	Для меня в приоритете
Сохранить или улучшить состояние моего психического здоровья (например, в связи с депрессией, горем, тревожностью или избыточной агрессией)	
Получать особый уход или услуги (например, присоединиться к группе взаимоподдержки, получать медицинские процедуры или записываться на прием к врачу)	
Избегать не устраивающих меня способов лечения в кризисном состоянии. Разработать предварительное психиатрическое распоряжение	
Не ложиться в больницу	
Обращаться в больницу/к врачу/к терапевту при необходимости	
Сократить или исключить употребление психоактивных веществ	
Вести учёт своих лекарств и рецептов	
Осуществлять уход за собой (например, одеваться, купаться, готовить, делать покупки, заниматься финансами)	
Вести активный образ жизни (например, заниматься ходьбой, плаванием, лечебной физкультурой или реабилитационной терапией)	
Проводить свободное время (например, занимаясь хобби или волонтерством, посещая мероприятия или путешествуя)	
Продолжать работать или заниматься волонтерством, найти работу	
Откладывать деньги или получать финансовую поддержку/услуги	
Проводить время с друзьями и семьей	
Продолжать жить по своей вере и придерживаться религиозных убеждений	
Заниматься образовательной деятельностью (например, получить аттестат общей эквивалентности (GED), поступить в колледж, получить профессиональную аккредитацию или лицензию)	
Получить юридическую поддержку (например, получение помощи в опеке над детьми, составлении предварительного психиатрического распоряжения или получение других юридических услуг).	
Избежать столкновения с системой правосудия (например, успешное завершение испытательного срока, избежание тюрьмы)	
Поддерживать безопасность	
Переехать в другое жилье, найти постоянное место жительства (например, переехать к родственникам, найти отдельное жилье)	
Получать услуги и поддержку (например, записаться на получение государственных пособий на продукты питания, услуги социальных служб, транспортные услуги)	
Получить поддержку в преодолении проблем, связанных с моим хроническим заболеванием и получением должного ухода	
Напишите свой вариант:	

RESOURCE 12:
Behavioral Health Goal Inventory—Simplified Chinese

行为健康目标清单最重要的事情

选择一个您想和您的护理团队一起努力实现的目标。您可以调整这些目标或写出您自己的目标。在对您来说最重要的事宜旁边标记一个“**X**”。

	我的优先事项
改善或保持我的心理健康（例如，抑郁、悲伤、焦虑或愤怒）	
获得特定的护理或服务（例如医疗手术、加入同伴支持小组或医生预约）	
当我陷入健康危机时，避免我不想要的治疗——制定一份精神健康预立指示	
避免前往医院	
在需要时去医院/看医生/治疗师	
减少或消除药物使用	
管理药物或处方	
能够照顾自己（例如，穿衣、洗澡、做饭、购物或理财）	
进行身体活动（例如，散步、游泳、健身或职能治疗活动）	
参加康乐活动（例如，培养爱好、社区活动、旅游或做志愿者）	
继续工作或做志愿者，找一份工作	
攒钱或获得财务支持/服务	
与朋友和家人共度时光	
参与宗教活动或进行灵修	
寻求教育（例如，获得普通教育证书、进入大学学习或获得专业认证或执照）	
获得法律支持（例如，子女监护权、精神健康预立指示或其他法律服务方面的援助）	
避免卷入司法系统（例如，完成缓刑，避免监狱）	
确保安全	
搬到其他地方居住，寻找稳定的住所（例如，与家人同住，寻找独立住所）	
获得服务和支持（例如，申请政府福利，如食物资源、社会服务资源、交通服务等）	
在应对我的慢性病和护理需求方面获得支持	
自行填写：	

RESOURCE 13:
Behavioral Health Goal Inventory—Spanish

Lista de objetivos de salud conductual: Lo que más importa

Seleccione un objetivo en el que le gustaría trabajar con su equipo de atención. Puede cambiar estos objetivos o escribir los suyos. Marque con una **"X"** al lado del área más importante para usted.

	Prioridad para mí
Mejorar o mantener mi salud mental (por ejemplo, depresión, dolor, ansiedad o ira)	
Obtener atención o servicios específicos (por ejemplo, procedimientos médicos, unirme a un grupo de apoyo, concertar una cita con el médico)	
Evitar los tratamientos que no deseo cuando estoy en crisis, elaborar directivas psiquiátricas anticipadas	
Permanecer fuera del hospital	
Ir al hospital, médico o terapeuta cuando lo necesito	
Reducir o eliminar el consumo de sustancias	
Gestionar medicamentos o recetas	
Cuidar de mí mismo/a (por ejemplo, vestirme, bañarme, cocinar, hacer compras o manejar mis finanzas)	
Estar físicamente activo/a (por ejemplo, caminar, nadar, hacer ejercicios de terapia física u ocupacional)	
Realizar actividades recreativas (por ejemplo, pasatiempos, eventos comunitarios, viajes o voluntariado)	
Continuar trabajando o hacer voluntariado, encontrar un empleo	
Ahorrar dinero u obtener ayuda o servicios financieros	
Pasar tiempo con amistades y familiares	
Llevar una vida religiosa o espiritual	
Realizar actividades educativas (por ejemplo, obtener el GED, matricularme en la universidad o conseguir acreditación o licencia profesional)	
Obtener apoyo legal (por ejemplo, ayuda con la custodia de los hijos, directivas psiquiátricas anticipadas u otros servicios legales)	
Evitar verme implicado/a en el sistema judicial (por ejemplo, terminar la libertad condicional o no ir a la cárcel)	
Mantenerme seguro	
Mudarme a un hogar diferente, buscar una vivienda estable (por ejemplo, mudarme con la familia, buscar una vivienda independiente)	
Recibir servicios y apoyo (por ejemplo, inscribirme para recibir beneficios del gobierno como recursos alimentarios, recursos de servicios sociales, servicios de transporte)	
Recibir apoyo para hacer frente a mi enfermedad crónica y a mis necesidades de cuidados	
Escriba una prioridad suya:	

RESOURCE 14:
Behavioral Health Goal Inventory—Traditional Chinese

行為健康目標清單最重要的事情

選擇一個您想和您的護理團隊一起努力實現的目標。您可以調整這些目標或寫出您自己的目標。在對您來說最重要的事宜旁邊標記一個"**X**"。

	我的優先事項
改善或保持我的心理健康（例如，抑鬱、悲傷、焦慮或憤怒）	
獲得特定的護理或服務（例如醫療手術、加入同伴支持小組或醫生預約）	
當我陷入健康危機時，避免我不想要的治療——制定一份精神健康預立指示	
避免前往醫院	
在需要時去醫院/看醫生/治療師	
減少或消除藥物使用	
管理藥物或處方	
能夠照顧自己（例如，穿衣、洗澡、做飯、購物或理財）	
進行身體活動（例如，散步、游泳、健身或職能治療活動）	
參加康樂活動（例如，培養愛好、社區活動、旅遊或做志願者）	
繼續工作或做志願者，找一份工作	
攢錢或獲得財務支持/服務	
與朋友和家人共度時光	
參與宗教活動或進行靈脩	
尋求教育（例如，獲得普通教育證書、進入大學學習或獲得專業認證或執照）	
獲得法律支持（例如，子女監護權、精神健康預立指示或其他法律服務方面的援助）	
避免捲入司法系統（例如，完成緩刑，避免監獄）	
確保安全	
搬到其他地方居住，尋找穩定的住所（例如，與家人同住，尋找獨立住所）	
獲得服務和支持（例如，申請政府福利，如食物資源、社會服務資源、交通服務等）	
在應對我的慢性病和護理需求方面獲得支持	
自行填寫：	

RESOURCE 15:
Behavioral Health Goal Inventory—Vietnamese

Danh sách mục tiêu sức khỏe hành vi: Điều quan trọng nhất

Chọn một mục tiêu mà bạn muốn thực hiện với đội ngũ chăm sóc của mình. Bạn có thể thay đổi những mục tiêu này hoặc viết mục tiêu của riêng bạn. Đánh dấu "**X**" bên cạnh phần quan trọng nhất đối với bạn.

	Ưu tiên của tôi
Cải thiện hoặc duy trì sức khỏe tâm thần của tôi (ví dụ: trầm cảm, đau buồn, lo lắng hoặc tức giận)	
Nhận dịch vụ hoặc chăm sóc cụ thể (ví dụ: thủ thuật y tế, tham gia nhóm hỗ trợ đồng đẳng, lên lịch hẹn với bác sĩ)	
Tránh các phương pháp điều trị mà tôi không muốn khi đang khủng hoảng - lập chỉ thị trước về chăm sóc sức khỏe tâm thần	
Không phải đến bệnh viện	
Đến bệnh viện/bác sĩ/chuyên gia trị liệu khi cần	
Giảm hoặc ngừng sử dụng chất kích thích	
Quản lý thuốc men hoặc đơn thuốc	
Chăm sóc bản thân (ví dụ: mặc quần áo, tắm rửa, nấu ăn, mua sắm hoặc tài chính)	
Tích cực vận động thể chất (ví dụ: đi bộ, bơi lội, thực hiện các bài tập trị liệu vật lý hoặc trị liệu chức năng hoạt động)	
Thực hiện các hoạt động giải trí (ví dụ: sở thích, sự kiện cộng đồng, du lịch hoặc tình nguyện)	
Tiếp tục làm việc hoặc tham gia hoạt động tình nguyện, tìm một việc làm	
Tiết kiệm tiền hoặc nhận hỗ trợ/dịch vụ tài chính	
Dành thời gian với bạn bè và gia đình	
Thực hành đời sống tôn giáo hoặc tâm linh	
Theo đuổi các hoạt động giáo dục (ví dụ: lấy bằng GED, đăng ký học đại học hoặc lấy chứng nhận hay giấy phép hành nghề)	
Nhận hỗ trợ pháp lý (ví dụ: hỗ trợ nuôi con, chỉ thị trước về chăm sóc sức khỏe tâm thần, hoặc các dịch vụ pháp lý khác)	
Tránh liên quan đến hệ thống tư pháp (ví dụ: hoàn thành thời gian thử thách, tránh bị vào tù)	
Giữ an toàn	
Chuyển đến một ngôi nhà khác, tìm nơi ở ổn định (ví dụ: cùng gia đình chuyển đến nơi ở mới, tìm nhà ở độc lập)	
Nhận dịch vụ và sự hỗ trợ (ví dụ: đăng ký nhận các phúc lợi của chính phủ như nguồn thực phẩm, nguồn dịch vụ xã hội, dịch vụ vận chuyển)	
Nhận sự hỗ trợ trong việc xử lý tình trạng mãn tính và đáp ứng những nhu cầu chăm sóc của tôi	
Viết mục tiêu của riêng bạn:	

RESOURCE 16:
General Goal Inventory—English

Goal Inventory: What Matters Most

Select a goal you would like to work on with your care team. You can change these goals or write your own. Mark an "**X**" next to the area that is most the most important to you.

	Priority for me
Control symptoms (for example, fatigue, pain, nausea, sleep, shortness of breath, depression, anxiety)	
Get specific care or services (for example, medical procedure, wheelchair, transportation or doctor's appointment)	
Avoid treatments I don't want	
Get treatment to keep me alive as long as possible	
Go to the hospital when I need to	
Stay out of the hospital	
Avoid accidents, such as falls	
Care for myself (for example, dressing, bathing, cooking, shopping or finances)	
Be physically active (for example, walking, swimming, doing physical or occupational therapy exercises)	
Do recreational activities (for example, hobbies, community events, travel or volunteer)	
Continue to work or volunteer, find a job	
Spend time with friends and family	
Attend an important event (for example a wedding, graduation, work event, take a trip)	
Practice religious or spiritual life	
Keep memory sharp	
Improve or maintain my mental health (for example, depression, grief, anxiety or anger)	
Continue to live at home	
Move to a different home, find stable housing (for example, move in with family, assisted living)	
Manage end-of-life affairs (for example complete a will, advance directive, or other financial or legal affairs)	
Receive support in coping with my chronic condition and care needs	
My family members/friends receive support in coping with my chronic condition and care needs	
Write your own:	

RESOURCE 17:
General Goal Inventory—Arabic

وضع قائمة الأهداف: أهم ما يريده الشخص

اختر هدفًا ترغب في العمل على تحقيقه مع فريق رعايتك. ولك أن تغيّر هذه الأهداف وأن تكتب كذلك هدفًا آخر تنشده. ضع علامة **"X"** أمام الشيء الأهم بالنسبة لك.

	أولوياتي
السيطرة على الأعراض (كأعراض الإرهاق، والألم، والغثيان، والنوم، وصعوبة التنفس، والاكتئاب، والقلق)	
أتلقى رعاية أو خدمة محددة (مثل: إجراء طبي محدد، أو كرسي متحرك، أو خدمة نقل، أو موعد لزيارة طبيب)	
أتجنب العلاج الذي لا أرغب فيه	
أتلقى العلاج لكي أحيا أطول مدة ممكنة	
أذهب إلى المستشفى متى احتجت إلى ذلك	
أبتعد عن المستشفى	
أتجنب الحوادث، كالسقوط على الأرض	
أعتني بنفسي (أي مثلًا أرتدي ملابسي، وأستحم، وأطهو طعامي، وأتسوق، وأنفق مالي بنفسي)	
أتمتع بالنشاط البدني (كممارسة المشي، والسباحة، وتمارين العلاج الطبيعي والوظيفي، مثلًا)	
أمارس أنشطة ترفيهية (كالهوايات، أو حضور الفعاليات المجتمعية، أو السفر، أو التطوع)	
أواصل العمل أو التطوع أو أحصل على وظيفة	
أجالس أهلي وأصدقائي	
أحضر فعالية مهمة (كحفل زفاف، أو تخرج، أو فعالية مهمة في العمل، أو أقوم برحلة)	
أمارس شعائر دينية أو روحية	
أحافظ على قوة ذاكرتي	
أحسّن صحتي النفسية أو أحافظ عليها (من الاكتئاب، والحزن، والقلق، والغضب، وغيرها)	
أستمر في العيش بمنزلي	
أنتقل إلى منزل آخر أو أحصل على مسكن دائم (كالعيش مع الأسرة، أو في دار من دور رعاية المساعدة المعيشية)	
أخلّص أمور نهاية العمر (مثل كتابة الوصية، أو وصية المرضى المسبقة للرعاية الحرجة، أو الأمور المالية والقانونية الأخرى)	
أتلقى المساعدة في تعايشي مع مرضي المزمن واحتياجات رعايتي	
أن يتلقى أهلي وأصدقائي الدعم في التعايش مع مرضي المزمن واحتياجات رعايتي	
اكتب هدفًا آخر تنشده:	

RESOURCE 18:

General Goal Inventory—Russian

Выбор целей. Что важнее всего

Выберите цель, над которой вы хотели бы работать вместе со своей командой по уходу. Вы можете изменить эти цели или добавить свои собственные. Поставьте **«X»** напротив наиболее важной для вас сферы.

	Для меня в приоритете
Контроль симптомов (например, усталость, боль, тошнота, сонливость, одышка, депрессия, тревожность)	
Получать конкретный уход (например, медицинская процедура, кресло-коляска, организация транспорта или запись на прием к врачу)	
Избегать способов лечения, которые меня не устраивают	
Получать лечение для продления моей жизни на максимально возможный срок	
Отправляться в больницу, когда мне это необходимо	
Избегать больницы	
Избегать несчастных случаев, таких как падения	
Уход за собой (например, одевание, купание, приготовление пищи, покупки и финансы)	
Вести активный образ жизни (например, ходьба, плавание, занятия лечебной физкультурой или реабилитационной терапией)	
Организация досуга (например, хобби, общественные мероприятия, путешествия или волонтерство)	
Продолжать работать или быть волонтером, найти работу	
Проводить время с друзьями и семьей	
Посетить важное мероприятие (например, свадьбу, выпускной, рабочее мероприятие, предпринять поездку)	
Продолжать жить согласно моей вере или религиозным убеждениям	
Сохранить хорошую память	
Сохарнить или улучшить состояние моего психического здоровья (например, в связи с депрессией, горем, тревожностью или избыточной агрессией)	
Продолжать жить дома	
Переехать в другой дом, найти постоянное жилье (например, переехать к семье, проживание с уходом)	
Завершить важные дела (например, составление завещания, заблаговременное распоряжение или другие финансовые или юридические дела)	
Получить поддержку в преодолении моего хронического заболевания, а также должный уход, связанный с ним	
Чтобы мои родственники/друзья получили поддержку в связи с моим хроническим заболеванием и потребностями в уходе	
Напишите свой вариант:	

RESOURCE 19:
General Goal Inventory—Simplified Chinese

目标清单：最重要的事情

选择一个您想和您的护理团队一起努力实现的目标。您可以调整这些目标或写出您自己的目标。在对您来说最重要的事宜旁边标记一个“**X**”。

	我的优先事项
控制症状（例如，疲劳、疼痛、恶心、嗜睡、呼吸短促、抑郁、焦虑）	
获得特定的护理或服务（例如，医疗手术、轮椅、往返交通或医生预约）	
避免接受我不想要的治疗	
获得治疗，尽可能长久地活着	
需要时可去医院	
远离医院	
避免意外，如跌倒	
能够照顾自己（例如，穿衣、洗澡、做饭、购物或理财）	
进行身体活动（例如，散步、游泳、健身或职能治疗活动）	
参加康乐活动（例如，培养爱好、社区活动、旅游或做志愿者）	
继续工作或做志愿者，找一份工作	
与朋友和家人共度时光	
参加重要活动（例如婚礼、毕业典礼、工作事宜、出游）	
参与宗教活动或进行灵修	
保持记忆清晰	
改善或保持我的心理健康（例如，抑郁、悲伤、焦虑或愤怒）	
继续在家中生活	
搬家，找到稳定住所（例如，搬去与家人同住，获得协助生活服务）	
管理临终事务（例如，完成遗嘱、预立医疗指示或其他财务或法律事宜）	
在应对我的慢性病和护理需求方面获得支持	
我的家人/朋友在应对我的慢性病和护理需求方面得到支持	
写出您自己的目标：	

RESOURCE 20:
General Goal Inventory—Spanish

Inventario de las metas: Lo que más importa

Seleccione una prioridad en que le gustaría trabajar con su equipo médico. Puede cambiar estas metas o escribir los suyos. Marque con una **"X"** al lado de las áreas que son más importantes para usted.

	Prioridad para mí
Controlar los síntomas (por ejemplo, fatiga, dolor, náuseas, sueño, dificultad para respirar o estreñimiento)	
Obtener atención o servicios específicos (por ejemplo, procedimiento médico, silla de ruedas, transporte o cita con el médico)	
Evitar los tratamientos que no quiero	
Recibir tratamiento para mantenerme con vida el mayor tiempo posible	
Ir al hospital cuando lo necesito	
Permanecer fuera del hospital	
Evitar accidentes, como caídas	
Cuidar de mí mismo (por ejemplo, vestirme, bañarme, cocinar, hacer compras o manejar mis finanzas)	
Estar físicamente activo (por ejemplo, caminar, nadar, hacer ejercicios de terapia física u ocupacional)	
Realizar actividades recreativas (por ejemplo, pasatiempos, eventos comunitarios, viajes o voluntariado)	
Continuar trabajando o hacer voluntariado o encontrar trabajo	
Pasar tiempo con amigos y familiares	
Asistir a un evento importante (por ejemplo, una boda, una graduación, un evento de trabajo, un viaje)	
Practicar la vida religiosa o espiritual	
Mantener la memoria aguda	
Mejorar o mantener mi salud mental (por ejemplo, depresión, dolor, ansiedad o ira)	
Continuar viviendo en casa	
Mudarse a un hogar diferente o encontrar un hogar más estable (por ejemplo, mudarse con la familia, vivienda asistida)	
Gestionar asuntos relacionados con el final de la vida (por ejemplo, completar un testamento, instrucciones anticipadas u otros asuntos financieros o legales)	
Recibir apoyo para enfrentar mi enfermedad grave y mis necesidades de atención	
Que mis familiares y amigos reciban apoyo para hacer frente a enfermedades y necesidades de atención	
Escriba una prioridad suya:	

RESOURCE 21:
General Goal Inventory—Traditional Chinese

目標清單：最重要的事情

選擇一個您想和您的護理團隊一起努力實現的目標。您可以調整這些目標或寫出您自己的目標。
在對您來說最重要的事宜旁邊標記一個"**X**"。

	對我來說屬優先的事項
控制症狀（例如，疲勞、疼痛、噁心、嗜睡、呼吸短促、抑鬱、焦慮）	
獲得特定的護理或服務（例如，醫療手術、輪椅、往返交通或醫生預約）	
避免接受我不想要的治療	
獲得治療，盡可能長久地活著	
需要時可去醫院	
遠離醫院	
避免意外，如跌倒	
能夠照顧自己（例如，穿衣、洗澡、做飯、購物或理財）	
進行身體活動（例如，散步、游泳、健身或職能治療活動）	
參加康樂活動（例如，培養愛好、社區活動、旅遊或做志願者）	
繼續工作或做志願者，找一份工作	
與朋友和家人共度時光	
參加重要活動（例如婚禮、畢業典禮、工作事宜、出遊）	
參與宗教活動或進行靈修	
保持記憶清晰	
改善或保持我的心理健康（例如，抑鬱、悲傷、焦慮或憤怒）	
繼續在家中生活	
搬家，找到穩定住所（例如，搬去與家人同住，獲得協助生活服務）	
管理臨終事務（例如，完成遺囑、預立醫療指示或其他財務或法律事宜）	
在應對我的慢性病和護理需求方面獲得支持	
我的家人/朋友在應對我的慢性病和護理需求方面得到支持	
寫出您自己的目標：	

RESOURCE 22:
General Goal Inventory—Vietnamese

Danh sách Mục tiêu: Những điều Quan trọng Nhất

Chọn một mục tiêu mà bạn muốn thực hiện với nhóm chăm sóc của mình. Bạn có thể thay đổi những mục tiêu này hoặc viết mục tiêu của riêng bạn. Đánh dấu "**X**" bên cạnh phần quan trọng nhất đối với bạn.

	Ưu tiên của tôi
Kiểm soát các triệu chứng (ví dụ, mệt mỏi, đau, buồn nôn, giấc ngủ, thở dốc, trầm cảm, lo âu)	
Nhận dịch vụ hoặc sự chăm sóc cụ thể (ví dụ, thủ thuật y tế, xe lăn, dịch vụ đưa đón hoặc cuộc hẹn với bác sĩ)	
Tránh các phương pháp điều trị mà tôi không muốn	
Nhận phương pháp điều trị để giúp tôi sống càng lâu càng tốt	
Đến bệnh viện khi tôi cần	
Không phải đến bệnh viện	
Tránh gặp tai nạn, chẳng hạn như té ngã	
Chăm sóc bản thân (ví dụ, mặc quần áo, tắm rửa, nấu ăn, mua sắm hoặc tài chính)	
Hoạt động thể chất (ví dụ, đi bộ, bơi lội, thực hiện các bài tập trị liệu vật lý hoặc trị liệu chức năng hoạt động)	
Thực hiện các hoạt động giải trí (ví dụ như các sở thích, sự kiện cộng đồng, đi du lịch hoặc làm tình nguyện)	
Tiếp tục làm việc hoặc tham gia hoạt động tình nguyện, tìm một việc làm	
Dành thời gian với bạn bè và gia đình	
Tham dự một sự kiện quan trọng (ví dụ như đám cưới, lễ tốt nghiệp, sự kiện ở nơi làm việc, đi du lịch)	
Thực hành đời sống tôn giáo hoặc tâm linh	
Rèn luyện để trí nhớ được minh mẫn	
Cải thiện hoặc duy trì sức khỏe tinh thần của tôi (ví dụ như trầm cảm, đau buồn, lo lắng hoặc tức giận)	
Tiếp tục sống ở nhà	
Chuyển đến một ngôi nhà khác, tìm nơi ở ổn định (ví dụ, chuyển đến sống cùng người thân, cơ sở hỗ trợ sinh hoạt)	
Quản lý các công việc ở giai đoạn cuối đời (ví dụ, hoàn thành di chúc, chỉ dẫn trước hoặc các công việc về tài chính hoặc pháp lý khác)	
Nhận được sự hỗ trợ trong việc xử lý tình trạng mạn tính và đáp ứng những nhu cầu chăm sóc của tôi	
Người thân/bạn bè của tôi nhận được sự hỗ trợ trong việc xử lý tình trạng mạn tính và đáp ứng những nhu cầu chăm sóc của tôi	
Viết mục tiêu của riêng bạn:	

RESOURCE 23:
Goal Inventory for Care Partner—English

Care Partner Goal Inventory: What Matters Most

Select a goal you would like to work on with your care team. You can change these goals or write your own.
Mark an "**X**" next to the area that is most the most important to you.

Goal Examples	My Priority
Help the person I care for...	
Control symptoms (like fatigue, pain, insomnia, shortness of breath, nausea, constipation)	
Get specific care, service or equipment (for example, a wheelchair, transportation services, doctor appointments)	
Reduce medications they take	
Avoid treatments they do not want	
Stay out of the hospital or emergency department	
Go to the hospital when they need to	
Get treatments to stay alive as long as possible	
Avoid accidents (for example, falls) or household hazards	
Be physically active (for example, walking, exercise, physical or occupational therapy)	
Care for themselves (for example, dressing, bathing, cooking, shopping, finances)	
Do recreational activities (for example, hobbies, travel, volunteer)	
Attend an important event (for example, a wedding, graduation, work event, trip)	
Keep their memory sharp	
Improve their mental health (for example, manage depression, anxiety, stress)	
Continue to live at home	
Move to a different home (for example, move in with family, assisted living)	
Continue to work	
Spend time with friends and family	
Practice religious or spiritual life	
Manage end-of-life affairs (for example, complete a will, advance directive, other financial or legal affairs)	
Help me...	
Receive support in coping with caregiving	
Receive support in coping with the illness of the person I care for	
Have more free time for myself outside of caregiving	
Receive help in managing my own health care needs	
Minimize family conflict about caregiving	
Add custom goal:	

RESOURCE 24:
Goal Inventory for Care Partner—Arabic

قائمة أهداف شريك الرعاية أهم ما يريده الشخص

اختر هدفًا للشخص الذي تتولى رعايته أو ترغب في العمل على تحقيقه مع فريق الرعاية. ولك أن تغيّر هذه الأهداف وأن تكتب كذلك هدفًا آخر تنشده. ضع علامة **"X"** أمام الشيء الأهم بالنسبة لك وللشخص الذي تتولى رعايته.

	أولوياتي
مساعدة الشخص الذي أتولى رعايته في...	
السيطرة على الأعراض (مثل التعب والألم والأرق وضيق التنفس والغثيان والإمساك)	
تلقي رعاية أو خدمة أو الحصول على معدات محددة (مثل، كرسي متحرك أو خدمات الانتقال أو حجز موعد لزيارة طبيب)	
تقليل الأدوية التي يتناولها المريض	
تجنب العلاج الذي لا يرغب فيه المريض	
تجنب الذهاب إلى المستشفى أو قسم الطوارئ	
اللجوء إلى المستشفى عند الحاجة	
تلقي العلاج للبقاء على قيد الحياة أطول فترة ممكنة	
تجنب الحوادث، كالسقوط أو الأعمال المنزلية المحفوفة بالمخاطر	
التمتع بالنشاط البدني (كممارسة المشي، والتمارين الرياضية، وتمارين العلاج الطبيعي والوظيفي)	
مساعدته على العناية بنفسه (مثل ارتداء الملابس والاستحمام، وطهي الطعام، والتسوق، وتدبير الأمور المالية)	
ممارسة الأنشطة الترفيهية (كالهوايات، أو السفر، أو التطوع)	
حضور فعالية مهمة (كحفل زفاف، أو تخرج، أو فعالية مهمة في العمل، أو الذهاب في رحلة)	
الحفاظ على قوة ذاكرته	
تحسين صحته النفسية (على سبيل المثال، تجنب الاكتئاب، والقلق، والتوتر)	
مواصلة العيش بالمنزل	
الانتقال إلى منزل آخر (كالانتقال للعيش مع الأسرة، أو في دار من دور رعاية المساعدة المعيشية)	
مواصلة العمل	
قضاء الوقت مع الأهل والأصدقاء	
ممارسة الشعائر الدينية أو الروحانية	
العناية بالأمور المتعلقة بالوفاة وما بعدها (مثل كتابة الوصية، أو التوجيهات المسبقة أو الأمور المالية والقانونية الأخرى)	
مساعدتي على...	
الحصول على دعم في التكيف مع تقديم الرعاية	
الحصول على دعم في التكيف مع مرض الشخص الذي أتولى رعايته	
تخصيص المزيد من وقت الفراغ لنفسي خارج نطاق تقديم الرعاية	
الحصول على المساعدة في إدارة احتياجات الرعاية الصحية الخاصة بي	
التقليل من الخلافات العائلية حول تقديم الرعاية	
اكتب هدفًا آخر تنشده:	

RESOURCE 25:
Goal Inventory for Care Partner—Russian

Выбор целей партнера по уходу. Что важнее всего?

Выберите цель для человека, за которым вы ухаживаете, или цель, над которой вы хотели бы работать вместе с командой по уходу. Вы можете изменить эти цели или добавить свои собственные. Поставьте **«X»** напротив цели, являющейся наиболее важной для человека, за которым вы ухаживаете, и для вас.

	Для меня в приоритете
Помочь человеку, за которым я ухаживаю…	
Контролировать симптомы (например, усталость, боль, бессонницу, одышку, тошноту, запор)	
Получать специфический уход, услуги или оборудование (например, кресло-коляску, организацию транспорта или запись на прием к врачу)	
Сократить количество принимаемых лекарств	
Избегать лечения, которого он/она не хочет	
Не посещать больницу или отделение неотложной помощи	
Посещать больницу при необходимости	
Получать лечение, чтобы жить как можно дольше	
Избегать несчастных случаев, таких как падения или бытовые травмы	
Вести активный образ жизни (например, делая физические упражнения или занимаясь ходьбой, лечебной физкультурой или реабилитационной терапией)	
Ухаживать за собой (например, одеваться, купаться, готовить, делать покупки, заниматься финансами)	
Проводить свободное время (например, занимаясь хобби, волонтерством или путешествуя)	
Посетить важное мероприятие (например, свадьбу, выпускной, рабочее мероприятие, совершить поездку)	
Сохранять хорошую память	
Улучшить свое психическое здоровье (например, справляться с депрессией, тревогой, стрессом)	
Продолжать жить дома	
Переехать в другой дом (например, переехать к родственникам или в жилье с уходом)	
Продолжать работать	
Проводить время с друзьями и семьей	
Продолжать жить по своей вере и придерживаться религиозных убеждений	
Решение вопросов, связанных с окончанием жизни (например, составление завещания, заблаговременного распоряжения или решение других финансовых и юридических дел)	
Мне нужна помощь и поддержка...	
Чтобы преодолеть проблемы, связанные с уходом за больным	
Чтобы справиться со стрессом из-за болезни человека, за которым я ухаживаю	
Чтобы иметь больше свободного времени для себя, не связанного с уходом	
Чтобы обеспечить свои медицинские потребности	
Чтобы свести к минимуму семейные конфликты, связанные с уходом	
Напишите свой вариант:	

RESOURCE 26:
Goal Inventory for Care Partner—Simplified Chinese

护理伙伴目标清单：最重要的事情

请为您所护理的人士选择一个目标，或与护理团队一起为该人士选择一个目标。您可以调整这些目标或写出您自己的目标。在对您和您所护理的人士最重要的目标旁标记"**X**"。

	我的优先事项
帮助我所护理的人士……	
控制症状（如疲劳、疼痛、失眠、呼吸短促、恶心、便秘）	
获得特定的护理、服务或设备（例如轮椅、交通服务或医生预约）	
减少他/她所服用的药物剂量	
避免他/她不接受的治疗	
避免出现需前往医院或急诊室的情况	
必要时带他/她去医院	
接受治疗以尽可能延长生命	
避免意外事故，如跌倒或家庭安全隐患	
积极锻炼身体（例如散步、运动、进行物理治疗或职业治疗）	
照顾好自己（例如穿衣、洗澡、烹饪、购物、理财）	
进行休闲娱乐活动（例如爱好、旅行、志愿服务）	
参加重要活动（例如婚礼、毕业典礼、工作活动、旅行）	
保持他/她的记忆力敏锐	
改善他/她的心理健康状况（例如抑郁、焦虑、压力）	
继续在家中生活	
搬到不同的住所（例如，搬去与家人同住、入住协助生活服务设施）	
继续工作	
与朋友和家人共度时光	
参与宗教活动或进行灵修	
管理临终事务（例如，完成遗嘱、预立医疗指示或其他财务或法律事宜）	
帮助我……	
在应对护理方面获得支持	
在应对所护理人士的疾病方面获得支持	
在护理之余为自己争取更多自由时间	
在管理自己的健康护理需求方面获得帮助	
尽可能减少家庭与护理之间的冲突	
自行填写：	

RESOURCE 27:
Goal Inventory for Care Partner—Spanish

Lista de objetivos de la persona cuidadora: Lo que más importa

Seleccione un objetivo para la persona a su cuidado o en el que le gustaría trabajar con el equipo de cuidados. Puede cambiar estos objetivos o escribir los suyos. Marque con una **"X"** al lado del área más importante para usted.

	Prioridad para mí
Ayudar a la persona que cuido a:	
Controlar los síntomas (como fatiga, dolor, insomnio, dificultad para respirar, náuseas, estreñimiento)	
Obtener cuidados, servicios o equipos específicos (por ejemplo, una silla de ruedas, servicios de transporte o citas con el médico)	
Reducir la medicación que toma	
Evitar tratamientos que no desea	
Permanecer fuera del hospital o de la sala urgencias	
Acudir al hospital cuando lo necesite	
Recibir tratamientos para mantenerse con vida el mayor tiempo posible	
Evitar accidentes como caídas o peligros domésticos	
Mantenerse físicamente activo/a (por ejemplo, caminar, hacer ejercicio, hacer terapia física u ocupacional)	
Cuidar de sí mismo/a (por ejemplo, vestirse, bañarse, cocinar, hacer compras o manejar sus finanzas)	
Realizar actividades recreativas (por ejemplo, pasatiempos, viajes, voluntariado)	
Asistir a un acontecimiento importante (por ejemplo, boda, graduación, evento laboral, hacer un viaje)	
Mantener ágil la memoria	
Mejorar su salud mental (por ejemplo, depresión, ansiedad, estrés)	
Continuar viviendo en casa	
Mudarse a un hogar diferente (por ejemplo, mudarse con la familia, a una vivienda asistida)	
Continuar trabajando	
Pasar tiempo con amistades y familiares	
Llevar una vida religiosa o espiritual	
Gestionar asuntos relacionados con el final de la vida (por ejemplo, completar un testamento, realizar instrucciones anticipadas u ocuparse de otros asuntos financieros o legales)	
Ayudarme a:	
Recibir apoyo para hacer frente a los cuidados	
Recibir apoyo para hacer frente a la enfermedad de la persona a la que cuido	
Disponer de más tiempo libre para mí fuera del cuidado	
Recibir ayuda para gestionar mis propias necesidades médicas	
Minimizar los conflictos familiares relacionados con los cuidados	
Escriba una prioridad suya:	

RESOURCE 28:
Goal Inventory for Care Partner—Traditional Chinese

護理夥伴目標清單：最重要的事情

請為您所護理的人士選擇一個目標，或與護理團隊一起為該人士選擇一個目標。您可以調整這些目標或寫出您自己的目標。在對您和您所護理的人士最重要的目標旁標記"**X**"。

	我的優先事項
幫助我所護理的人士……	
控制症狀（如疲勞、疼痛、失眠、呼吸短促、噁心、便祕）	
獲得特定的護理、服務或設備（例如輪椅、交通服務或醫生預約）	
減少他/她所服用的藥物劑量	
避免他/她不接受的治療	
避免出現需前往醫院或急診室的情況	
必要時帶他/她去醫院	
接受治療以儘可能延長生命	
避免意外事故，如跌倒或家庭安全隱患	
積極鍛鍊身體（例如散步、運動、進行物理治療或職業治療）	
照顧好自己（例如穿衣、洗澡、烹飪、購物、理財）	
進行休閒娛樂活動（例如愛好、旅行、志願服務）	
參加重要活動（例如婚禮、畢業典禮、工作活動、旅行）	
保持他/她的記憶力敏銳	
改善他/她的心理健康狀況（例如抑鬱、焦慮、壓力）	
繼續在家中生活	
搬到不同的住所（例如，搬去與家人同住、入住協助生活服務設施）	
繼續工作	
與朋友和家人共度時光	
參與宗教活動或進行靈脩	
管理臨終事務（例如，完成遺囑、預立醫療指示或其他財務或法律事宜）	
幫助我……	
在應對護理方面獲得支持	
在應對所護理人士的疾病方面獲得支持	
在護理之餘為自己爭取更多自由時間	
在管理自己的健康護理需求方面獲得幫助	
儘可能減少家庭與護理之間的衝突	
自行填寫：	

RESOURCE 29:
Goal Inventory for Care Partner—Vietnamese

Danh sách mục tiêu của đối tác chăm sóc: Điều quan trọng nhất

Chọn một mục tiêu cho người mà bạn chăm sóc hoặc bạn muốn thực hiện với đội ngũ chăm sóc. Bạn có thể thay đổi những mục tiêu này hoặc viết mục tiêu của riêng bạn. Đánh dấu "**X**" bên cạnh một phần quan trọng nhất đối với người mà bạn chăm sóc và bạn.

	Ưu tiên của tôi
Giúp người tôi chăm sóc…	
Kiểm soát các triệu chứng (ví dụ: mệt mỏi, đau đớn, mất ngủ, khó thở, buồn nôn, táo bón)	
Nhận dịch vụ, thiết bị hoặc sự chăm sóc cụ thể (ví dụ: xe lăn, dịch vụ đưa đón hoặc cuộc hẹn với bác sĩ)	
Giảm dùng thuốc	
Tránh các phương pháp điều trị mà người ấy không mong muốn	
Không phải đến bệnh viện hoặc đi cấp cứu	
Đến bệnh viện khi cần	
Được điều trị để duy trì sự sống lâu nhất có thể	
Tránh gặp tai nạn, như té ngã hoặc mối nguy hiểm trong gia đình	
Tích cực vận động thể chất (ví dụ: đi bộ, bơi lội, trị liệu vật lý hoặc trị liệu chức năng hoạt động)	
Tự chăm sóc cho bản thân (ví dụ: mặc quần áo, tắm rửa, nấu ăn, mua sắm hoặc tài chính)	
Thực hiện các hoạt động giải trí (ví dụ: sở thích, du lịch, tình nguyện)	
Tham dự một sự kiện quan trọng (ví dụ: đám cưới, lễ tốt nghiệp, sự kiện ở nơi làm việc, đi du lịch)	
Duy trì trí nhớ minh mẫn	
Cải thiện sức khỏe tâm thần (ví dụ: trầm cảm, lo lắng, căng thẳng)	
Tiếp tục sống ở nhà	
Chuyển đến một ngôi nhà khác (ví dụ: cùng gia đình chuyển đến nơi ở mới, cơ sở hỗ trợ sinh hoạt)	
Tiếp tục làm việc	
Dành thời gian với bạn bè và gia đình	
Thực hành đời sống tôn giáo hoặc tâm linh	
Quản lý các công việc ở giai đoạn cuối đời (ví dụ: hoàn thành di chúc, chỉ thị trước, hoặc các công việc về tài chính hoặc pháp lý khác)	
Giúp tôi…	
Nhận sự hỗ trợ để đương đầu với công việc chăm sóc	
Nhận sự hỗ trợ để đối phó với bệnh tình của người tôi chăm sóc	
Có nhiều thời gian rảnh hơn cho bản thân ngoài công việc chăm sóc	
Nhận sự trợ giúp trong việc quản lý nhu cầu chăm sóc sức khỏe của bản thân tôi	
Giảm thiểu xung đột gia đình về công việc chăm sóc	
Viết mục tiêu của riêng bạn:	

MODULE 3:
Goal Attainment Scaling

In this module, you will learn:

- What goal attainment scaling is and its importance in practice.
- How to use goal attainment scaling.
- Common approaches to scaling goals.
- Common difficulties when implementing goal attainment scaling.
- Tips on following up with individuals using goal attainment scaling.

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OVERVIEW AND IMPORTANCE OF GOAL ATTAINMENT SCALING

Goal attainment scaling (GAS) is a structured approach to goal-setting that was originally developed for use in mental health settings[1] and has been widely used in rehabilitation[2,3] and geriatrics.[4,5] Using a continuum of five possible outcomes (worse, current status, realistic goal, stretch goal, super stretch goal), an individual works with their clinician to define what it means to achieve the goal. The scaled goal is then used to develop a plan detailing the actions necessary to achieve it. At follow-up, the goal is reviewed, progress toward the goal is monitored and the goal is revised, if needed or desired. This process provides an opportunity for continual appraisal and feedback that can be adapted throughout an individual's care.

These goals are very important for me. I learned to cope with my pain, learned different directions to keep myself busy from the pain. After the first year I started to look on the other side, like wow, I can do this! I'm reminded every day when my caregiver comes in and says, "You want to go for a walk, or you want to go to the store?" I went four years without even going into a store, and just had a ball going to the store the first time. So yeah, they're very important to me.

Individual—57-year-old White, Non-Hispanic, female

USING GOAL ATTAINMENT SCALING

Goal attainment scaling takes practice. It can take 8–10 times of going through the process before feeling comfortable with it. Clinicians are encouraged to adapt this process to fit their existing workflows and procedures. The steps in the person-centered outcomes (PCO) approach can take place over multiple visits, and can occur in person, over the telephone or virtually, but at a minimum, there is:

- A **baseline visit** to identify and document the individual's goal, scale the goal and make a plan to achieve the goal.
- A **follow-up visit** to evaluate the individual's progress, based on the scale developed during the baseline visit.

This structure can be adapted to fit the needs of an organization. In many organizations, there are opportunities for multiple follow-up visits, where progress can be evaluated and the individual can be engaged in discussions about barriers and successes. Goals can be changed or revised at follow-up visits, as well.

[1] Kiresuk, T. J. (1968). Goal attainment scaling: A general method for evaluating comprehensive community mental health programs. Community Mental Health Journal, 4(6), 443-453.

[2] Bovend'Eerdt, T. J. (2009). Writing SMART rehabilitation goals and achieving goal attainment scaling: a practical guide. Clinical Rehabilitation, 23(4), 352-361.

[3] Turner-Stokes, L. (2009). Goal attainment scaling (GAS) in rehabilitation: a practical guide. Clinical Rehabilitation.

[4] Morrow-Howell, N. Y. (1998). A standardized menu for goal attainment scaling in the care of frail elders. The Gerontologist, 38(6), 735-742.

[5] Rockwood, K. S. (1993). Use of goal attainment scaling in measuring clinically important change in the frail elderly. Journal of Clinical Epidemiology, 46(10), 1113-1118.

BASELINE VISIT

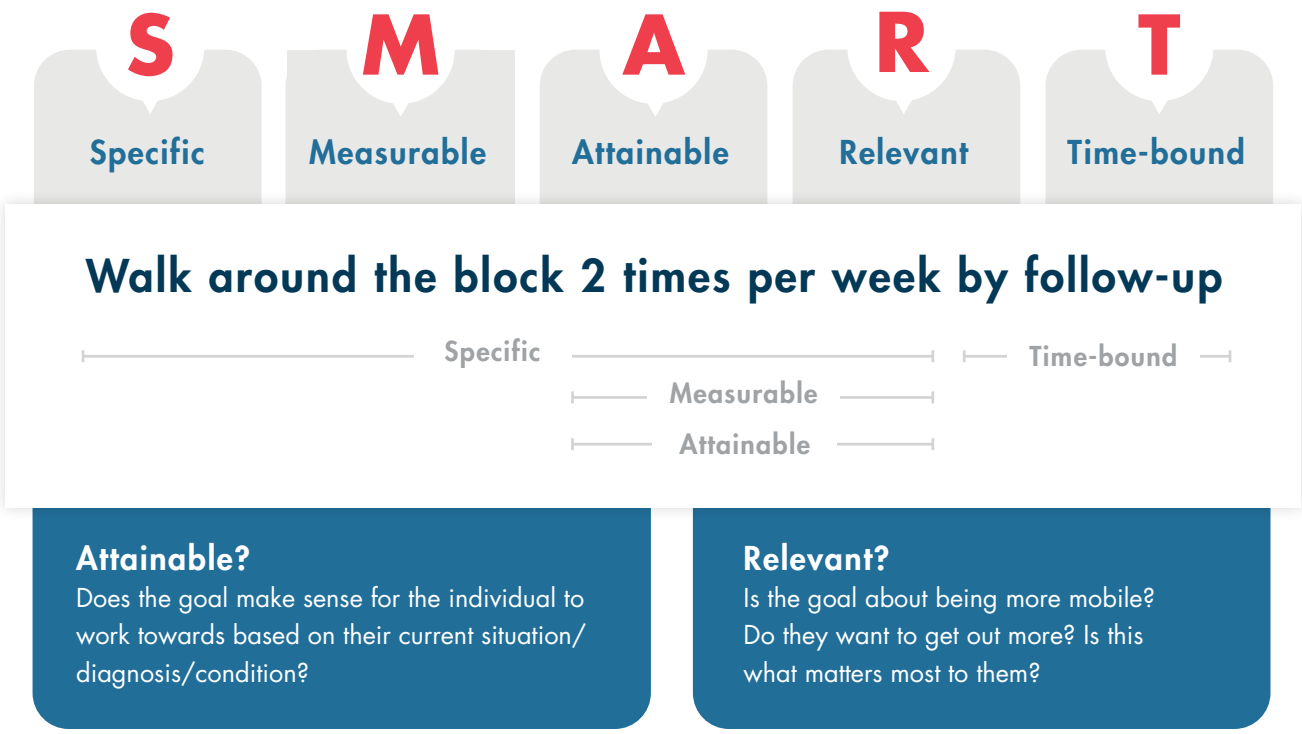
STEP 1:

Make sure the goal is SMART

(Refer to Module 2 for details on developing a SMART goal.)

Here's an example of a SMART goal: The individual wants to walk around the block two times per week by the follow-up visit.

This goal is **specific** because it focuses on one item to work toward (walking around the block twice per week). The goal is **measurable** because it is quantified (two times per week). When determining if the goal is **attainable**, ask, "Is this goal achievable for the individual to work toward, based on their current situation/diagnosis/condition? Can they walk around the block twice a week? Is that too much? Too little?" Is the goal **relevant**? Does this goal capture what matter most to the individual? Is their focus to become more mobile, or get out of the house more, and does the goal help them achieve that? And finally, the goal must be **time-bound**, focused on what can be done in a specific time (by a future follow-up visit). Based on the individual's condition, sometimes a follow-up is in four weeks, other times it may be in three months. The goal must be able to be accomplished, or progress made, by the follow-up date agreed on with the individual.



STEP 2:
Scale the goal

Worse (-2)	Current Status (-1)	Realistic Goal (0)	Stretch Goal (+1)	Super Stretch Goal (+2)
What would be worse?	Where are they now?	Where do they want to be in X weeks/months?	What would be a little better?	What is the best possible outcome?

1. Start by having the individual describe their current state. Place the "current status" description in the **-1 box**.
2. Identify the "realistic goal" outcome. Document this in the **0 box**. Ensure that the outcome is measurable.
3. Identify the "stretch goal" outcome and document this in the **+1 box**.
4. Identify the "super stretch goal" outcome and document this in the **+2 box**.
5. Identify the "worse" outcome and document this in the **-2 box**.

Example of Scaled Goal

Worse (-2)	Current Status (-1)	Realistic Goal (0)	Stretch Goal (+1)	Super Stretch Goal (+2)
Wake up 3-4 times a night and not fall asleep till after midnight	Wake up 3-4 times a night	Within the next two months, only wake up once a night	Within the next two months, not wake up at all during the night	Within the next two months, not wake up at all during the night and get a full 8 hours of sleep

STEP 3:
Create a plan to achieve the goal and address potential barriers to achievement

1. Develop a **plan to achieve the goal** with the individual. It can include actions the individual needs to take, actions the care partner needs to take (if applicable), actions you as the clinician need to take or actions other members of the care team need to take.
2. **Optional: Share a copy of the goal**, the scaled outcomes and the plan to achieve the goal with the individual. The plan can be printed to send home with the individual or mailed after the encounter. *(Refer to Resource 4 Baseline Goal Attainment Scaling Example.)*

COMMON APPROACHES TO SCALING GOALS

There are many approaches to scaling a goal. Here are some real-life examples. (*Refer to Resource 1: Goal Attainment Scaling Examples for additional examples of goals being scaled using goal attainment scaling.)*

OPTION 1: Scale the time frame for achieving a specific state.

When scaling time frames, it is often best to use a time range so follow-up can be rated if an exact timepoint is not achieved.

GOAL: Obtain a personal care assistant to provide care partner respite in 1-2 months.				
Worse (-2)	**Current Status (-1)**	**Realistic Goal (0)**	**Stretch Goal (+1)**	**Super Stretch Goal (+2)**
No personal care attend and lose help from daughter on weekends	No personal care attendant	Obtain personal care assistant in **1-2 months**	Obtain personal care assistant in **2 weeks-1 month**	Obtain personal care assistant in **less than 2 weeks**

OPTION 2: Scale the scope of achieving a specific state using a range of numbers.

When scaling activities, it's best to use a range of numbers so it's clear which outcome has been achieved, to avoid the possibility of two outcomes applying simultaneously. Each section of the scale should be mutually exclusive so it is clear which box should be checked, to avoid the possibility of two boxes applying simultaneously.

GOAL: Walk one block by the end of the month.				
Worse (-2)	**Current Status (-1)**	**Realistic Goal (0)**	**Stretch Goal (+1)**	**Super Stretch Goal (+2)**
Not able to get out of house at all in the month	Able to get out of house, but not able to walk to the end of the block by the end of the month	Able to walk **1 block** by the end of the month	Able to walk **2 blocks** by the end of the month	Able to walk **more than 2 blocks** by the end of the month

OPTION 3: Scale the scope of completing a specific activity by adding activities.

When scaling activities, each box should build on the other box (achieve the realistic level of achievement **and** stretch goal). Also consider how to scale the goal at follow-up if one activity is achieved in the "super stretch goal" but a "realistic" activity goal is not achieved.

GOAL: Create a resume within the next month to apply for jobs.				
Worse (-2)	**Current Status (-1)**	**Realistic Goal (0)**	**Stretch Goal (+1)**	**Super Stretch Goal (+2)**
Homeless because they can't pay their bills	No job; only have enough money to pay 6 more months of rent	Create a resume within the next month	Create a resume and find 5 jobs to submit an application in the next month	Create a resume, find and submit 5 jobs applications in the next month

OPTION 4: Scaling a large goal into more manageable actions.
Sometimes an individual's top priority is to remain in their home. This can be difficult to scale because there might be no immediate impediment to this goal. **Consider how to scale what would make living in the home easier or more assured.**

For example, if the goal is to remain at home for as long as possible for an individual at risk of falls, scale a goal specific to addressing safety issues in the home.

GOAL: Remain living at home for as long as possible by reducing fall risk in the next 3 months.				
Worse (-2)	**Current Status (-1)**	**Realistic Goal (0)**	**Stretch Goal (+1)**	**Super Stretch Goal (+2)**
Individual/care partner does not review bathroom safety with occupational therapist in the next 3 months and individual slips in the bathroom	Individual/care partner does not review bathroom safety with occupational therapist in the next 3 months	Individual/care partner reviews bathroom safety with occupational therapist in the next 3 months	Individual/care partner reviews bathroom safety with occupational therapist and **makes at least 1 improvement in the next 3 months**	Individual/care partner reviews bathroom safety with occupational therapist and **makes at least 2 improvements in the next 3 months**

OPTION 5: Scaling goals that are not related to a health condition, disability or a medical issue.
Sometimes goals are about doing something that brings an individual pleasure or purpose. Here is an example of a goal for a woman near the end of her life.

GOAL: Present a slide show of previous work in Africa to fellow residents in assisted living within 2 months.				
Worse (-2)	**Current Status (-1)**	**Realistic Goal (0)**	**Stretch Goal (+1)**	**Super Stretch Goal (+2)**
Cannot remember content of slides	Too weak to perform on the day of the show	Present slide show to a small group within the next 2 months	Present slide show to a larger group within the next 2 months	Present multiple slide shows within the next 2 months

COMMON DIFFICULTIES WITH GOAL ATTAINMENT SCALING

- **The goal has too many parts.** Sometimes individuals can have a goal that is too broad. If there are too many parts to a goal, it may be difficult to measure achievement if one part is met but another is not. Consider splitting complicated goals into two or more goals; ask the individual which goal they want to work on first and scale that goal.
- **Completing all goal attainment scaling boxes.** It can sometimes be difficult to fill all five points on the GAS, especially the endpoints. An individual who can't fill in the endpoints should talk more about their goal; extract parts from what they say. Guide the individual or suggest what to include, using known information such as their clinical history, their experience with previously set goals or what is currently happening in their lives. Think "baby steps." Ask, "How can this be a little bit better?"
  - » One technique is to use frequencies, or amounts of time, to achieve the goal. For example, if the expected outcome is to get dressed independently within 3 months, a "stretch goal" outcome could be to get dressed independently within 6 weeks and a "super stretch goal" outcome could be to get dressed independently within 2 weeks.

FOLLOW-UP VISIT

STEP 1:

Have a discussion to assess progress on the goal

Things Got Worse (-2)	No Progress on Goal (-1)	Achieved Realistic Goal (0)	Did Better Than Expected (+1)	Did Much Better Than Expected (+2)

RED FLAG

Any score **below 0** is a potential red flag

GOAL ACHIEVEMENT

Any score of **0 or above** means individual achieved goal

Discuss the individual's progress on the goal. Document the progress rating of both the individual and the clinician, based on the -2 to +2 scale developed during the baseline visit. If **both the individual and clinician** document a progress score of 0 or above, the individual achieved the goal. A score of -1 or below means the individual did not make progress on the goal, or got worse; this could be a red flag.

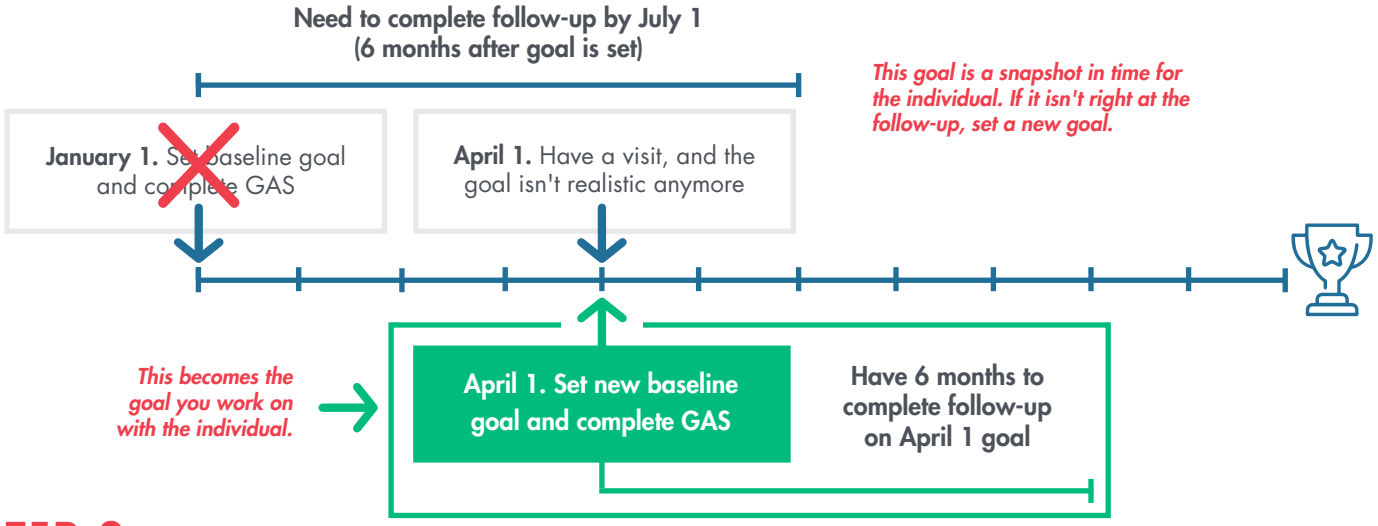
STEP 2:

What to do if the individual DID NOT achieve their goal

Not meeting the "expected" level is not a failure; it can be an opportunity to discuss the goal and its scaling. If the goal was unrealistic, it can be changed or rescaled. If the individual identified new barriers to achieving the goal, this is an opportunity to work through them. If the goal is no longer important to the individual, a new goal can be set.

- Sometimes a goal changed because the individual's status or circumstances changed. Sometimes individuals just change their minds. **Be patient; this is a new process for them as well**, and they may still be discovering what is most important to them. Document progress on the current goal, even if the individual wants to change a goal.

- PCO measures require a baseline visit, a follow-up visit and a rating of achievement once during the measurement period, within 6 months of when the goal was identified and documented to meet measure requirements, but goals should be set and followed up on throughout the year.
  For example, for a goal set on January 1, follow-up should occur within 6 months. During the follow-up visit on April 1, the individual says they want to change the goal because it is no longer realistic. Set a new goal, complete the scale for the new goal and develop an action plan. The new goal developed on April 1 is now the main goal. Complete a follow-up on the new goal within 6 months.



STEP 2:

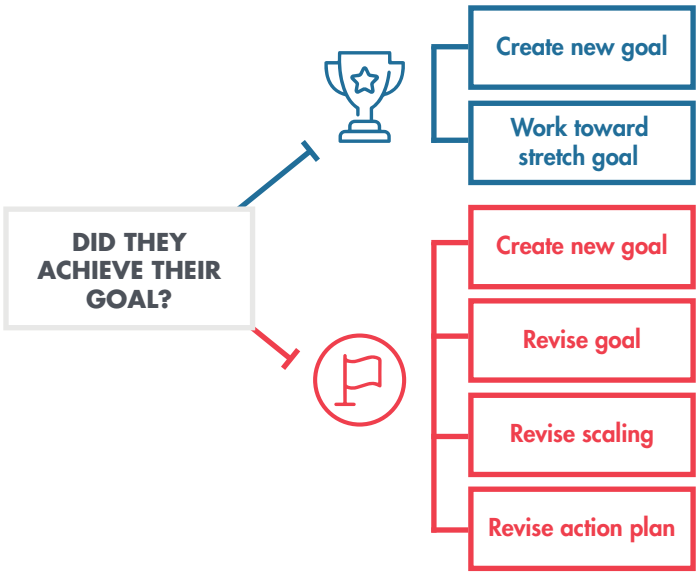
What to do if the individual ACHIEVED their goal

If the individual achieved the goal, **celebrate their success**! Celebrating with the individual is important and can be a motivating process. For some people, achieving the goal helps them get closer to their desired quality of life. They can now work toward the "stretch" (+1) or "super stretch" (+2) goal, or they can set a new goal. Talk about the values identified in previous conversations to determine what to work on next.

STEP 3:

Determine next steps based on achievement

With the individual, decide on the best next step in setting a goal. The image at right shows different options, depending on if the individual achieved the goal or not. The next step will help determine documentation.
For example, if the individual did not achieve their goal and the clinician and individual decide to revise the scaling, document the updated 5-point scale again as well as the action steps. If the clinician and individual choose to create a new goal, the new goal as well as the new scaling and action steps will need to be documented.



Follow-Up Timing

The PCO measures *Goal Follow-Up and Goal Achievement* require follow-up no later than 6 months from when the goal was identified to assess goal achievement. Follow-up may also be at an intermediate point; for example, for a goal set at 6 weeks, a check in at 2–3 weeks, to see if the individual is making progress or needs additional assistance, can be a reminder and a motivator. It is also useful to hear about barriers to meeting a goal, in case additional support is needed.

ASSESSING FIDELITY TO THE PERSON-CENTERED OUTCOME APPROACH

When implementing the PCO approach, periodic review of the data is recommended to ascertain fidelity to the process. Data review is critical to ensuring that quality measure results are valid and reliable. As assessment of validity aims to understand whether the underlying data are correct, assessment of reliability aims to understand whether data are documented consistently. Some questions to ask when reviewing the data:

- How complete are the data? Are some data elements routinely undocumented?
- Does the goal content vary? Although individuals in certain populations may lean toward similar goals areas, there will be some variation. Lack of variation may indicate that goals do not reflect the individual's priorities.
- Are the documented goals SMART?

Checklist to remember when documenting and scaling a goal:

- ✓ Is the goal SMART (Specific, Measurable, Attainable, Realistic, Time-bound)?
- ✓ Have you completed all five levels of the scale?
- ✓ Have you identified where they are now in -1?
- ✓ Do the scale and goal relate to only one topic?
- ✓ Is each level of the scale measurable?
- ✓ Is there an action plan to help the individual reach their goal?

If the individual's not willing to work and do the job themselves, then goal setting is kind of pointless. But my husband is willing to do it because he wants to get better. He doesn't want to constantly have help to get dressed. He's been able to put on his outfit and put his shoes on. It is like, "Wow, I can actually do that. I can actually get down and I can tie my shoes now, and I can put on my socks." So it's been a bigger step forward than what I had figured now he has gotten better, and he's getting stronger.

Care partner—63-year-old White female, Non-Hispanic

RESOURCE 1:
Goal Attainment Scaling Examples

GOAL	Scaling of Goal				
	Worse (-2)	Current Status (-1)	Realistic Goal (0)	Stretch Goal (+1)	Super Stretch Goal (+2)
Hire home health aide (HHA) in the next 2 months	No HHA in the home, Pt is unable to go out and declines more rapidly due to not having assistance	No HHA in the home	Choose 2-3 HHA options from list provided by clinician in the next 2 months	Hire HHA in the next 2 months	HHA coming to the home 2 days a week in the next 2 months
Figure out what is owed for medical bills in 1 month	Very confused about medical bills; bills more disorganized	Bills organized in piles; confused about what is owed	Call 2 companies w/in 1 month to ask questions	Outstanding bill for 1 company paid in 1 month	Outstanding bill for 2 companies paid in 1 month
Get rid of 1 bag of mail	Accumulate more mail	Currently 4 bags of unread mail	1 bag sorted per week	1-1/2 bags sorted per week	2 bags of mail sorted per week
Lose 10 pounds in 3 months	Weight >200 lbs.	Weight is 200 lbs.	Weigh 190 lbs. in 3 months	Weigh 180-189 lbs. in 3 months	Weigh 170-179 lbs. in 3 months
Increase energy	Active 0 minutes before short of breath (SHOB)	Active 15 minutes a day before SHOB	Active 30 minutes a day before SHOB	Active 45 minutes a day before SHOB	Active 1 hour a day before SHOB
Get out of bed 3 days a week over the next 2 months	Completely bed bound	Not getting out at all, or minimally	Sit in the living room 2-3 days a week in the next	Sit in the living room 4-5 days a week in the next 2 months	Sit in the living room 6-7 days a week in the next 2 months
Be more physically active—be able to be active 45 minutes a day	Not be able to walk 1 mile each day	Walk 30 minutes per day in 2 sessions inside the house	Walk 45 minutes per day within the next 2 months	Walk 46-60 minutes per day in the next 2 months	Walk 61-75 minutes per day within the next
Consistently walk down the hallway once per day, 7 days per week, by the end of April 2020	Only able to do the walk down the hallway less than 3 days per week	Walk down the hallway once per day, 3-4 days per week	Consistently walk down the hallway 1 time per day, 7 days per week by the end of April 2020	Consistently walk down the hallway 2 times per day, 7 days per week by the end of April 2020	Consistently walk down the hallway 3 times per day, 7 days per week by the end of April 2020
Sleep 2 hours undisturbed a couple days a week in the next 2 months	Falling asleep in the bathroom while smoking	Falling asleep in front of the TV	Sleep 2 hours undisturbed 1-2 days a week	Sleep 4 hours undisturbed 3-4 days a week	Sleep 6 hours undisturbed 5-7 days a week
Stay hydrated so I can avoid having to go to the ER	Drink less than I do now, which is 64 ounces at least 4 days per week	Drinking 64 ounces 4 days per week	Drink 64 ounces 5 days per week	Drink 64 ounces 6 days per week	Drink 64 ounces 7 days per week

GOAL	Scaling of Goal				
	Worse (-2)	Current Status (-1)	Realistic Goal (0)	Stretch Goal (+1)	Super Stretch Goal (+2)
Be able to get out of the house and go for a drive in the country with my wife at least 1 time a week in the next 3 months	Be down in bed all the time and my wife would no longer be able to care for me	I stay at home all the time because it is too painful to walk and I am afraid of getting an infection	Get out of the house and go for a drive in the country with my wife at least 1 time a week in the next 3 months	Get out of the house and go for a drive in the country with my wife at least 2 times a week in the next 3 months	Get out of the house and go for a drive in the country with my wife at least 3 times a week in the next 3 months
Stay away from drugs and identify treatment for my substance use in the next 30 days so I can be a better father	Not look for rehab center, and drug use increases	Currently using drugs daily	Identify two rehab centers within the next 30 days	Enroll in treatment/ rehab over the next 30 days	Attend treatment twice a week over the next 30 days
Get a job	Not employed and going back to jail	Not employed	Create a resume within a month	Create a resume and apply to 2 jobs in 2 months	Create a resume and apply to 4 jobs in 2 months
Go to church more often	Do not attend church at all over the next 3 months	Attend church infrequently	Attend church once a month over the next 3 months	Attend church 2-3 times a month over the next 3 months	Attend church weekly over the next 3 months
Start working with Senior Home Advisor to understand options in 2 months to gain more affordable housing	Run out of funds before finding new housing	Unable to afford current housing	Meet with Senior Home Advisor to explore affordable housing options	Create list of viable options of affordable housing	Visit at least 1 potential housing option
Comply with psychiatric services by taking my medication daily as prescribed	Symptoms get worse and I have to go to the ED	Do not currently take prescribed psychiatric medication	Take medication daily as prescribed for 1 month	Take medication daily as prescribed for 2 months	Take medication daily as prescribed for 3 months

RESOURCE 2:
Goal Attainment Scaling Script

Introduction

Before coming in today, you identified goals that were important regarding your care. We are going to review your most important goal now. *(Refer to Goal Inventory Resources in Module 2.)*

Review Top Goal

Is this goal the most important for your care over the next X months? (Read top goal aloud.)

- **If yes:** We are going to focus on how you can meet this goal.
- **If no:** What goal would you identify as your top, most important goal? We are going to focus on how you can meet this goal.

Baseline Visit

Now we will focus on the goal you ranked as most important. This table will help us see what the goal looks like.

How would you describe where you are with this goal right now?
(Document the current state in the "current state" box [-1 box].)

Describe what it would look like/mean to meet this goal in the next X months?
(Document this in the "realistic goal" box [0 box].)

What would it look like/mean to do even better on this goal?
(Document this in the "stretch goal" box [+1 box].)

What is the best possible outcome of this goal, something that is much better than what you expect to achieve?
(Document this in the "super stretch goal" box [+2 box].)

Now let's think about what would be worse than where you are now. What could happen if we don't work on this goal?
(Document this in the "worse" box [-2 box].)

A. Review (Review the outcomes written for each stage, confirming that the individual [and care partner] agree with the outcomes documented.)

Okay, let's review what we just discussed. (Read goal and outcomes.)

B. Develop a Care Plan

Thank you. Now, let's talk about a plan to help you achieve this goal. What steps do you need to take to help you achieve this goal? What can I do to help you achieve this goal?

Follow Up Visit

Revise this script to fit the follow-up time frame.

A. Assess Progress

At your last visit, we discussed goals that were important to you. Your goal was [goal]. Since your last visit, how much progress have you made on this goal?

Written in the boxes are the things you wanted to achieve for this goal. Of those things, what do you think you've achieved? Let's look at what was in the expected/realistic goal box first. (Review each box and assess whether the outcome was achieved.)

So, how would you rate your progress on this goal—would you say you got worse, made no progress, met your goal, met your stretch goal or met your super stretch goal?

(Document your rating of progress and the individual's rating of progress, based on the 5-point scale.)

B. If Goal Was NOT Achieved

If an individual is struggling to achieve their goal, the first step is a conversation to understand what the progress is and what the barriers are. Ask clarification questions about why the goal was not achieved:

- Does this goal still apply to you?
  - » If the goal is no longer relevant to the individual, ask "Would you like to select a new goal to work towards? (Repeat GAS baseline process as necessary.)
- Do you agree with what is written in the boxes?
  - » **If yes**, ask questions to understand what barriers are stopping them from completing the goal. You might need to reassess the action steps or follow-up time frame. Once you have identified the barriers and revised the scaling and action steps (if needed), complete the follow-up GAS session and schedule another follow up, as necessary.
  - » **If no**, ask, "Would you like to keep this goal, but revise what is written in the boxes?" Revise the GAS boxes as necessary, complete the follow-up GAS session and schedule another follow up, as necessary.

C. If Goal Was Achieved

If the individual achieved the goal, celebrate their success! Celebrating with the individual is important and can be a motivating process. For some people, achieving the goal helps them get closer to their desired quality of life. They can now work toward the "stretch" or "super stretch" goal, or they can set a new goal. Talk about the values identified in previous conversations to determine what to work on next.

RESOURCE 3:
Goal Attainment Scaling via Role-Play

Practice

- Select one person to role-play the clinician and one person to role-play the individual.
- Choose a case that best fits your care population. Role-play setting the goal, documenting the goal using GAS and creating an action plan.
- For the remaining cases, switch roles and repeat the exercise.

CASE #1

Mrs. R is an 89-year-old Mexican, Spanish-speaking (limited English, in Los Angeles since the 1950s), straight female with moderate dementia, with anxiety and nighttime behaviors. Her husband passed away 2 years ago. She needs functional assistance with day-to-day activities. She lives with her daughter, son-in-law and granddaughter. The family is concerned about wandering (a neighbor found her outside the home a few months ago) and falls (the last fall was 1 month ago: she tripped on steps at home and bruised her arm). Mrs. R's daughter, who provides most of her daily care, reports feeling very strained trying to balance her job and taking care of her mother.

Mrs. R used to enjoy going for walks around her neighborhood and to the senior center down the street, but due to her functional limitations and fall risk, she has been unable to do either activity.

CASE #2

Mr. K is a 45-year-old Asian, gay male with metastatic colon cancer, in for a follow-up visit. On his last CT scan, 1 week ago, he had new lung, liver and abdominal metastases. He has an appointment to discuss the findings with his oncologist next week. His husband accompanies him to the visit today, and is tearful in the visit. He is scared that the chemo is no longer working, and is worried about treatment options available to his husband.

Mr. K reports worsening nausea and abdominal pain over the last few weeks. He has been using his pain pills and nausea medication more frequently, and missed work last week due to worsening symptoms. He makes service calls for a heating, ventilation and air conditioning company, and is worried about being able to pay his bills if he can't return to work, since his husband is a stay-at-home dad.

There is no advance directive in the patient's chart or on file. The couple reports that they completed a will 10 years ago, after the birth of their third child, but have never completed an advance directive or living will.

CASE #3

Ms. H is a 75-year-old White, lesbian female with severe COPD, on 3L of oxygen at home, in addition to stage III chronic kidney disease and knee osteoarthritis. She is a widow who lives alone. She hired a part-time caregiver (Mon–Fri, 9am-12pm) to help with meal preparation, housework, laundry and transportation. Her appetite is poor; she eats only one meal on most days. She can shower by herself, but worries she will fall. During the day, she watches TV, reads and naps.

She is largely homebound, and has been out of the house only twice in the last several months, due to shortness of breath. She is lonely. She volunteered at a local elementary school library, until about 2 years ago, when her breathing began to worsen. Her son lives nearby and visits most days after work. Her daughter lives out of state and tries to visit once a month.

Ms. H also reports a fall 4 days ago. She lost her balance getting off the toilet. She scraped her left arm on the vanity in the fall and sustained a skin tear, which she bandaged herself at home. She has been using a rollator walker since the fall, and feels more stable with it, but has declined physical therapy because she is very fatigued when leaving her home.

CASE #4

Ms. X is a 43-year-old Black, straight, single female presenting for her intake appointment. She scored 13 on the PHQ-9 (reflecting moderate depression), and is seeking counseling. She is tearful today, as she reports a history of experiencing symptoms of depression and loneliness, but this is the first time she has sought treatment.

Ms. X lives in a 2-bedroom house with her adult son. Ms. X has multiple sclerosis and doesn't drive; her son provides her transportation. Since the COVID-19 pandemic, Ms. X reports that she has stopped going out much and socializing. In that time, her house has become disorganized and cluttered, and the upkeep overwhelms her. When asked about goal setting, Ms. X has several significant changes she would like to make to her life and circumstances, including improving her mental health, socializing more, exercising more and cleaning up her house and other home improvement projects.

CASE #5

Mr. Y is a 35-year-old White, straight male with comorbid alcohol and opioid use disorder, as well as hepatitis C. He is here today for a follow-up appointment. Mr. Y has had past interactions with the justice system as a result of his substance use, and has court ordered requirements to engage in treatment.

Mr. Y is currently unemployed, temporarily lives with his brother and does not have access to reliable transportation. He reports that his involvement with the justice system has made it difficult to obtain employment, and lack of transportation has made it difficult to keep employment. Mr. Y has a young child. He does not have custody, due to his poor relationship with the mother, but says he wants to be more involved in the child's life.

Mr. Y reports that he has been drinking since he was a teenager, and began using opioids in the last 2 years. He has received treatment for his alcohol use, but did not find it helpful. He is resistant to goal setting because he must meet requirements related to his involvement with the justice system.

CASE #6

Ms. Z is a 24-year-old, Hispanic, bilingual (Spanish and English speaking), queer female referred for follow-up services after an ED and subsequent psychiatric inpatient stay for psychosis. Ms. Z had been experiencing delusions and paranoia, expressing that the secret service was planning to kidnap her and take her to Washington, DC. Ms. Z had not been taking any antipsychotic medications or engaging in treatment prior to her most recent hospitalization.

Ms. Z lives with her parents in a two-bedroom apartment. She lives in an urban area, and can walk or use public transportation. She is currently unemployed. She had taken college-level courses, but is not currently enrolled. Ms. Z is resistant to medications; she reports undesirable side effects from the medications she received while hospitalized, and does not want to feel that way again. During the visit, Ms. Z exhibits flat affect while describing her current circumstances, and expresses wanting increased stability and control in her life.

PRACTICE

1. **Identify top values.** Identify and document the individual's values.
    - Connecting with others (friends/family, community, spirituality).
    - Enjoying life (productivity, personal growth, recreation).
    - Functioning (independence, dignity).
    - Managing health (symptoms, quality of life).

2. **Complete the phrase for each value:** The one thing the individual wants to focus on is _____, so they can _____ more often or more easily.

3. **Have the individual decide on ONE goal to work toward and make the goal SMART.**

Document the goal using GAS. Specify the follow-up time frame. Develop an action plan to help the individual understand their role and the role of the clinician in completing the goal.

GOAL	Worse (-2)	Current Status (-1)	Realistic Goal (0)	Stretch Goal (+1)	Super Stretch Goal (+2)
	What would be worse?	Where are they now?	Where do they want to be in X time?	What would be a little better?	What is the best possible outcome?
ACTION PLAN					

Remember, when documenting and scaling a goal:

- Is the goal SMART (Specific, Measurable, Attainable, Realistic, Time-Bound)?
- Have you completed all five levels of the scale?
- Have you identified where the individual is now in -1?
- Do the scale and goal relate to only one topic?
- Is each level of the scale measurable?
- Is there an action plan to help the individual reach their goal?

Feeling stuck?

- Link back to values. ***"Can I double check: Is this really important to you?"***
- Is the goal and scaling SMART?
- Take small steps toward a larger goal.
- Encourage supportive language (rather than punitive, self-judgmental language). ***"If you do this, what will be the benefits in the long term?"***
- Anticipate obstacles. ***"What might get in the way of doing that?"***
- Discuss the costs. ***"If you keep doing what you are doing, what will it cost in terms of your well-being?"***
- Recognize that discomfort sometimes comes with taking new steps. ***"Are you willing to feel some discomfort in order to do what matters to you?"***
- Don't allow your mind to bully you into giving up. ***"I'm too tired; I'm too busy; I'll fail."***
- Get support. ***"Maybe ask a friend to walk with you."***
- Use reminders. ***"Set an alarm on your phone or in your calendar."***

RESOURCE 4:
Baseline Goal Attainment Scaling Example

English

Visit date: June 20

Personal report for: Jessica Rose

Goal: Walk her dog outside once a week

LOGO HERE

Worse (-2)	Current Status (-1)	Realistic Goal (0)	Stretch Goal (+1)	Super Stretch Goal (+2)
Unable to let the dog outside	Does not go outside or walk her dog	Walk her dog outside once a week	Walk her dog outside twice a week	Walk her dog outside three times a week

What is holding you back?

Legs are weak, unable to walk more than 10 steps

Action plan:

1. Schedule in-home physical therapy services
2. Do home exercises 2–3 times a week

Next visit: August 1

Care manager: Keri

Phone number: 800-123-4567

RESOURCE 5:
Baseline Goal Attainment Scaling Form

English Blank Version

LOGO HERE

Visit date:

Personal report for:

Goal:

Worse (-2)	Current Status (-1)	Realistic Goal (0)	Stretch Goal (+1)	Super Stretch Goal (+2)

What is holding you back?

Action plan:

Next visit:

Care manager:

Phone number:

RESOURCE 6:
Baseline Goal Attainment Scaling Form

Russian Blank Version

Дата посещения:

Индивидуальный отчет для:

Цель:

LOGO HERE

Хуже (-2)	Текущее состояние (-1)	Реалистичная цель (0)	Сверхплановая цель (+1)	Амбициозная цель (+2)

Что вас сдерживает:

План:

Следующий визит:

Менеджер по уходу:

Номер телефона:

RESOURCE 7:
Baseline Goal Attainment Scaling Form

Arabic Blank Version

LOGO HERE

تاريخ الزيارة:

تقرير شخصي لـ:

الهدف:

أسوأ (2-)	الحالة الحالية (1-)	الهدف الواقعي (0)	الهدف الطَموح (1+)	الهدف الفائق الطُموح (2+)

الأمور التي تعوقك:

الخطة:

الزيارة القادمة:

مدير الرعاية:

رقم الهاتف:

RESOURCE 8:
Baseline Goal Attainment Scaling Form

Simplified Chinese Blank Version

LOGO HERE

就诊日期：

个人报告：

目标：

差 (-2)	当前状态 (-1)	现实目标 (0)	挑战目标 (+1)	超级挑战目标 (+2)

是什么原因阻碍了您：

计划：

下次就诊时间：

护理主管：

电话：

RESOURCE 9:
Baseline Goal Attainment Scaling Form

Spanish Blank Version

LOGO HERE

Fecha:

Nombre:

Meta:

Mucho menos de lo esperado (-2)	Menos de lo esperado (-1)	Nivel esperado (0)	Mejor de lo esperado (+1)	Mucho mejor de lo esperado (+2)

¿Qué le está deteniendo de alcanzar su meta?:

Pasos que me ayudarán alcanzar este meta:

Próxima Visita:

Medíco:

Número de Teléfono:

RESOURCE 10:
Baseline Goal Attainment Scaling Form

Traditional Chinese Blank Version

就診日期：

個人報告：

目標：

LOGO HERE

差 (-2)	當前狀態 (-1)	現實目標 (0)	挑戰目標 (+1)	超級挑戰目標 (+2)

是什麼原因阻礙了您：

行動計劃:

下次就診時間：

護理主管：

電話：

RESOURCE 11:

Baseline Goal Attainment Scaling Form

Vietnamese Blank Version

LOGO HERE

Ngày thăm khám:

Báo cáo cá nhân cho:

Mục tiêu:

Tệ hơn (-2)	Tình trạng Hiện nay (-1)	Mục tiêu Thực tế (0)	Mục tiêu Cần Nỗ lực (+1)	Mục tiêu Cần Rất nhiều Nỗ lực (+2)

Điều gì đang cản trở bạn:

Kế hoạch:

Lần thăm khám Tiếp theo:

Nhân viên Quản lý Chăm sóc:

Số Điện thoại:

TOOLKIT

MODULE 4:
Patient-Reported Outcome Measures

In this module, you will learn:

- What PROMs are and the importance of PROMs in practice.
- How to identify PROMs to include in a PROM bank.
- How to use PROMs.
- Tips on following up with individuals using PROMs.

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OVERVIEW AND IMPORTANCE

Patient-reported outcome measures (PROM) are standardized questionnaires that allow individuals to report on how they function or feel with respect to their health, quality of life, mental well-being or health care experience. PROMs have the potential to improve outcomes, particularly when used to manage treatment for a condition.[1] Questionnaire answers use a standardized scale to calculate an individual's score.[2] Changes in the score can be used to monitor whether functioning, symptoms or quality of life is improving over time.

The person-centered outcomes (PCO) approach allows clinicians, individuals and care partners to prioritize the most important PROM from a bank of potential PROMs *(Table 1)*. Clinicians and individuals discuss goals and jointly agree on an outcome the individual wants to improve. The clinician then selects and helps the individual complete a PROM for the identified outcome and uses it to track whether the individual is achieving their goal.

The biggest thing that surprised me was how quickly I recovered overall. I was working with my caregiver, started physical activity, and then started physical therapy. I went from not being able to walk after surgery and in constant pain, to walking my dogs every day, cleaning my house. Just that physical activity level every day has made a vast improvement over everything in my life... without having my clinician's help, I wouldn't quite be where I'm at today.

Individual—38-year-old, White Non-Hispanic, female

IDENTIFYING PROMS TO INCLUDE IN A PROM BANK

Before implementing the PCO approach, a clinician or organization must identify which PROMs to include in a PROM bank. We recommend tailoring the bank to an organization's population, with at least 8–10 PROMs to address a variety of person-centered goals. *(See Table 1 for a list of recommended PROMs)*. NCQA's measure testing primarily used PROMs from the Northwestern University Patient-Reported Outcome Measurement Information Set (**PROMIS**). The domains most selected were Physical Function, Mobility, Pain Interference with Daily Activities, Depression, Fatigue, Self-Efficacy to Manage Daily Activities, Self-Efficacy to Manage Symptoms, Self-Efficacy to Manage Health Needs, Caregiver Strain and Cognitive Function.

[1] Lavallee, D.C., Chenok, K. E., Love, R. M., Petersen, C., Holve, E., Segal, C. D., Franklin, P.D. (2016). Incorporating patient-reported outcomes into health care to engage patients and enhance care. Health Affairs, 35(4):575-582

Two additional PROMs that are used often are the PHQ-9 for depression and the GAD-7 for anxiety.[2,3]

Table 1. Recommended PROMS

PROMIS Tools	
Ability to Participate in Social Roles and Activities	Physical Function
Alcohol Use	Prescription Pain
Anger	Satisfaction with Social Role
Anxiety	Self-Efficacy for Managing Chronic Conditions: Manage Daily Activities
Cognitive Function	Self-Efficacy for Managing Chronic Conditions: Manage Medications and Treatments
Depression	Self-Efficacy for Managing Chronic Conditions: Manage Symptoms
Dyspnea Severity	Self-Efficacy for Managing Emotions
Fatigue	Severity of Substance Use—Past 3 Months
General Self-Efficacy	Severity of Substance Use—Past 30 Days
Informational Support	Sleep Related Impairment
Instrumental Support	Smoking: Coping Expectancies for All Smokers
Mobility	Smoking: Negative Health Expectancies for All Smokers
Pain Behavior	Smoking: Nicotine Dependence for All Smokers
Pain Interference with Daily Activities	Social Isolation
Non-PROMIS Tools	
General Anxiety Disorder-7 (GAD-7)	Patient Health Questionnaire (PHQ-9)

USING PROMS

The process for assessing person-centered outcomes using PROMs is described below. Clinicians are encouraged to adapt this process to fit their existing workflows and procedures. The steps in the PCO approach can take place over multiple visits, and can occur in person, over the telephone or virtually, but at a minimum, there is:

- A **baseline visit** occurs when the individual's goal is identified and recorded. The individual completes a PROM questionnaire and a plan to achieve the goal is created.
- A **follow-up visit** occurs when the individual completes the baseline PROM questionnaire again and the individual's progress on the PROM is evaluated.

This structure can be adapted to fit the needs of any organization. In many organizations, there are opportunities for multiple follow-up visits, where progress can be evaluated and the individual can be engaged in discussions about barriers and successes. Goals can be changed or revised at follow-up visits, as well.

[2] Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. Journal of general internal medicine, 16(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

[3] Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. Archives of internal medicine, 166(10), 1092–1097. https://doi.org/10.1001/archinte.166.10.1092

BASELINE VISIT

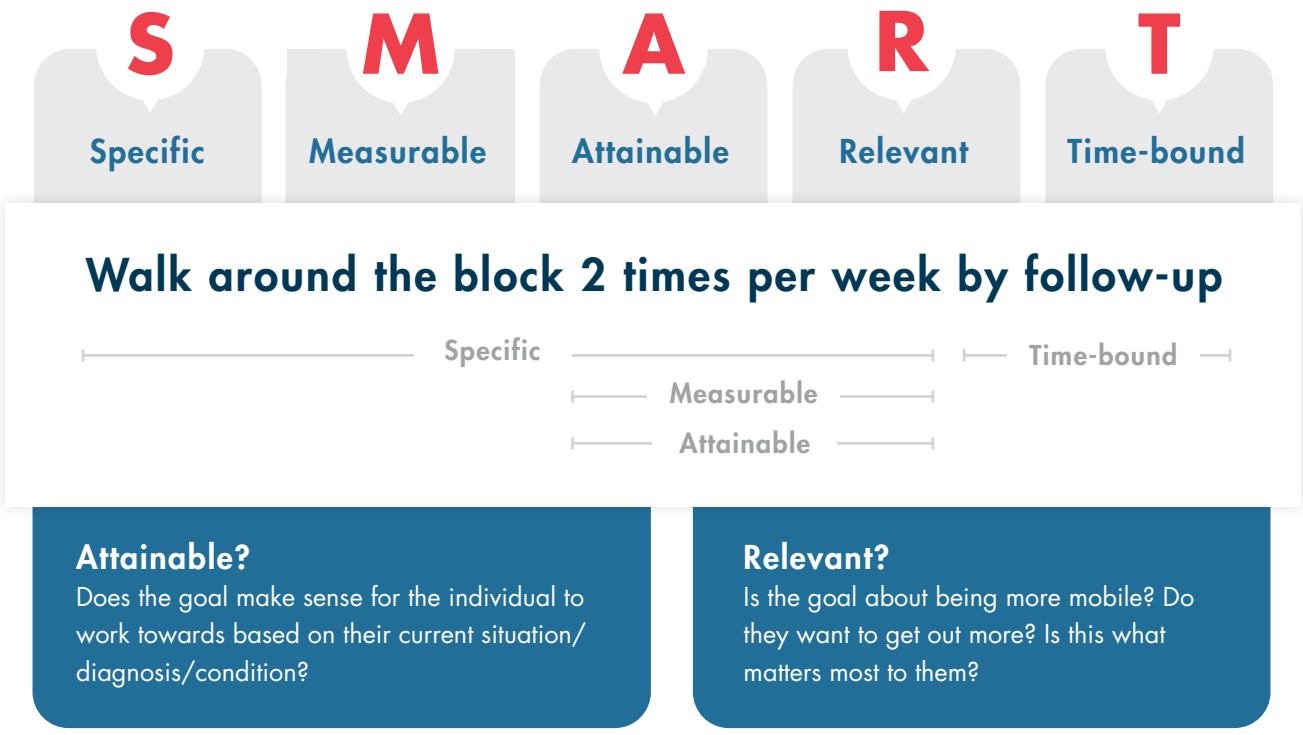
STEP 1:

Make sure the goal is SMART

(Refer to Module 2 for details on developing a SMART goal)

Here's an example of a SMART goal: The individual wants to walk around the block two times per week by the follow-up visit.

This goal is **specific** because it focuses on one item to work toward (walking around the block two times per week). The goal is **measurable** because it is quantified (two times per week). When determining if the goal is **attainable**, ask, "Is this goal achievable for the individual to work toward, based on their current situation/diagnosis/condition? Can they walk around the block twice a week? Is that too much? Too little?" Is the goal **relevant**? Does this goal capture what matter most to the individual? Is their focus to become more mobile, or get out of the house more, and does the goal help them achieve that? And finally, the goal must be **time-bound**, focused on what can be done in a specific time (by a future follow-up visit). Based on the individual's condition, sometimes a follow-up is in four weeks, other times it may be in three months. The goal must be able to be accomplished, or progress made, by the follow-up date agreed on with the individual.



STEP 2:

Determine which PROM will track the goal

PROMs focus on symptoms, mental health or general well-being. The PROM approach lets an individual select a standardized questionnaire that will provide a score for a symptom, function or other area of well-being.

There are two ways to choose a PROM; either can be used:

1. **Choose the PROM that best fits the goal topic.** In other words, match the goal with the PROM whose focus is related to the goal topic. For example, the PROMIS Physical Function is a good match if an individual's goal is to walk around the block. The PROMIS Self-Efficacy to Manage Medications PROM is a good match if an individual wants to take their medications consistently.
2. **Choose the PROM that fits the barrier to achieving the goal.** Have a conversation with the individual about what is holding them back, or what could hold them back, from achieving their goal. For example, choose the GAD-7 if an individual's goal is to go to an event with friends, but their anxiety prevents them from going. Choose the PHQ-9 if the individual wants to get a job, but their depression holds them back.

Administer the selected PROM by either having the individual complete it or by reading the questions out loud and marking the individual's responses. Show and explain the score to the individual (e.g., score range, whether a lower or a higher score is better).

STEP 3:

Create a plan to achieve the goal and address potential barriers to achievement

1. Develop a **plan to achieve the goal** with the individual. The goal can include actions the individual needs to take, actions the care partner needs to take (if applicable), actions you as the clinician need to take or actions other members of the care team need to take.
2. **Optional: Share a copy of the goal**, the completed PROM and the plan to achieve the goal with the individual. The plan can be printed to send home with the individual or mailed after the encounter. *(Refer to Resources: Baseline PROM Documentation Template.)*

FOLLOW-UP VISIT

STEP 1:

Readminister the PROM

Have the individual complete the same PROM that was completed during the baseline visit. Encourage the individual to fill out the PROM on their own, if they can. If they need help, read the PROM questions and response options aloud and mark the individual's answer to each item.

STEP 2:

Compare the follow-up score to the previous PROM score, and discuss the individual's progress on the goal

1. **Determine if there was a meaningful change between the baseline and follow-up PROM scores**. When using a PROM to document a PCO measure, meaningful change is specific to the PROM used *(Table 2)*

Table 2. Required score change for achievement/meaningful change

PROM TOOL	MEANINGFUL CHANGE
All PROMIS tools (refer to Table 1 for the list of potential PROMIS tools to choose from) ***Note:*** *A higher T-score represents more of the concept being measured. For example if using PROMIS Depression, the higher the score, the more depressed the individual is.*	3-point change from initial total T-score (increase/decrease depends on PROMIS tool used)
General Anxiety Disorder-7 (GAD-7)	4-point change from initial total raw score
Patient Health Questionnaire (PHQ-9)	5-point change from initial total raw score

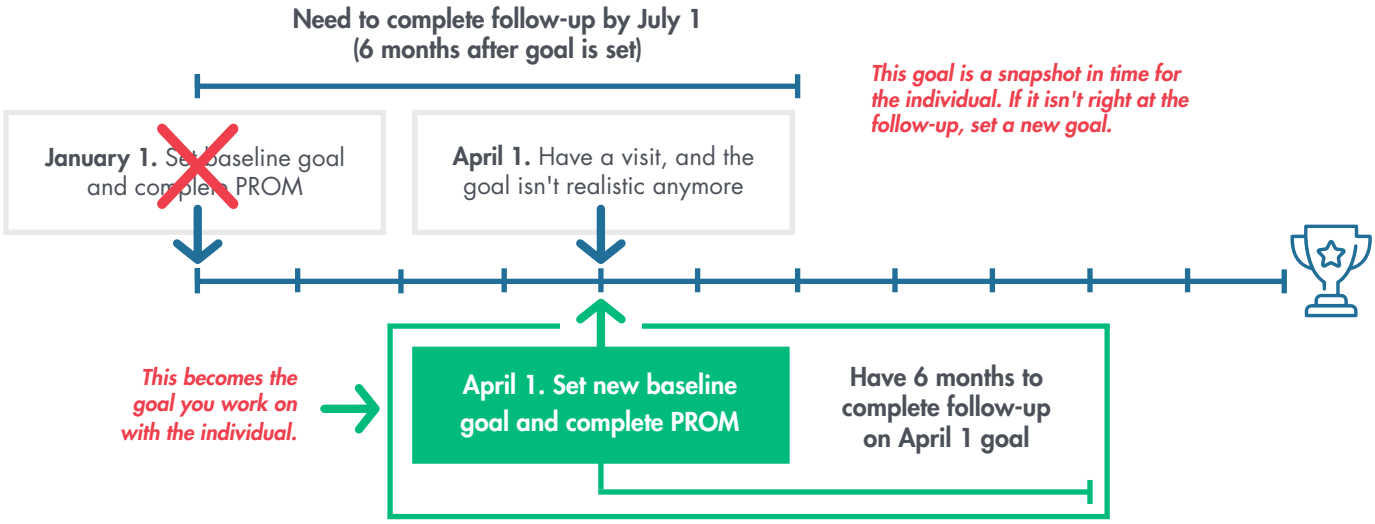
2. Ask the individual to tell you in their own words how they think they are doing and what progress they have made on their goal.

What to do if the individual DID NOT achieve their goal

Not having meaningful change between the baseline and follow-up PROM is not a failure; it can be an opportunity to discuss the goal. If the goal was unrealistic, it can be changed. If the individual identified new barriers to achieving the goal, this is an opportunity to work through them. If the goal is no longer important to the individual, a new goal can be set.

- Sometimes a goal changed because the individual's status or circumstances changed. Sometimes individuals just change their minds. **Be patient; this is a new process for them as well**, and they may still be discovering what is most important to them. Document progress on the current goal, even if the individual wants to change a goal.
- PCO measures require a baseline visit, a follow-up visit and a rating of achievement once during the measurement period, within 6 months of when the goal was identified and documented to meet measure requirements, but goals should be set and followed up on throughout the year.

  For example, for a goal set on January 1, follow-up should occur within 6 months. During the follow-up visit on April 1, the individual says they want to change the goal because it is no longer realistic. Set a new goal, choose and complete the PROM that is most relevant for the new goal and develop an action plan. The new goal developed on April 1 is now the main goal. Complete a follow-up on the new goal within 6 months.



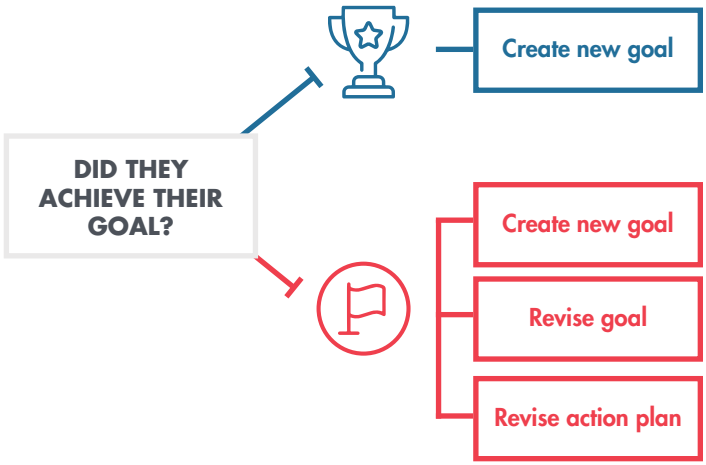
What to do if the individual ACHIEVED their goal

If the individual achieved the goal, **celebrate their success!** Celebrating with the individual is important and can be a motivating process. For some people, achieving the goal helps them get closer to their desired quality of life. They can now set a new goal. Talk about the values identified in previous conversations to determine what to work on next.

STEP 3:

Determine next steps based on achievement

With the individual, decide on the best next step in setting a goal. The image to the right shows different options, depending on if the goal was achieved or not. The next step will help determine documentation. For example, if the individual did not achieve their goal, the goal might need to be reviewed. If a new goal will be created, select and complete a new PROM and document the new action plan.



Follow-Up Timing

The PCO measures *Goal Follow-Up and Goal Achievement* require follow-up no later than 6 months from when the goal was identified to assess goal achievement. Follow-up may also be at an intermediate point; for example, for a goal set at 6 weeks, a check in at 2–3 weeks, to see if the individual is making progress or needs additional assistance, can be a reminder and a motivator. It is also useful to hear about barriers to meeting a goal, in case additional support is needed.

ASSESSING FIDELITY TO THE PERSON-CENTERED OUTCOME APPROACH

When implementing the PCO approach, periodic review of the data is recommended to ascertain fidelity to the approach. Data review is critical to ensuring that quality measure results are valid and reliable. As assessment of validity aims to understand whether the underlying data are correct, assessment of reliability aims to understand whether data are documented consistently. Some questions to ask when reviewing the data:

- How complete are the data? Are some data elements routinely undocumented?
- Does the goal content vary? Although individuals in certain populations may lean toward similar goals, there should be variation. Lack of variation may indicate that goals do not reflect the individual's priorities.
- Are the documented goals SMART?

The fact that the individuals were the ones coming up with their goal meant they were the ones determining if it was valuable to them and that was great. Asking questions, following it with the prompt, they were things they never even thought about. For example, they want to increase physical activity; well what does that mean? Does that mean you're doing yard work, you're walking miles? Those PROM questions really got them and me thinking about what it means to them—that was pretty helpful.

Clinician—Case management program in an integrated delivery system

RESOURCE 1:
Baseline PROM Documentation Template

English

Visit date:

Name:

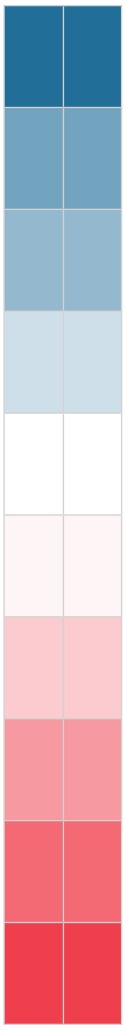
GOAL:

LOGO HERE

PROM

SCORE

BEST POSSIBLE



WORST POSSIBLE

What is holding you back?

Action plan:

Next follow-up:

Care manager:

Phone number:

RESOURCE 2:
Baseline PROM Documentation Template

Spanish

Fecha:

Nombre: :

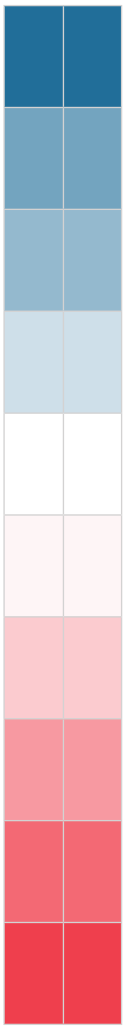
META:

LOGO HERE

PROM

Puntaje:

LO MEJOR POSIBLE



LO PEOR POSIBLE

¿Qué le está deteniendo de alcanzar su meta?:

Pasos que me ayudarán alcanzar este meta:

Próxima visita:

Médico:

Número de teléfono:

RESOURCE 3:
Baseline PROM Documentation Template

Arabic

أدرج شعار الشركة هنا

تاريخ الزيارة:

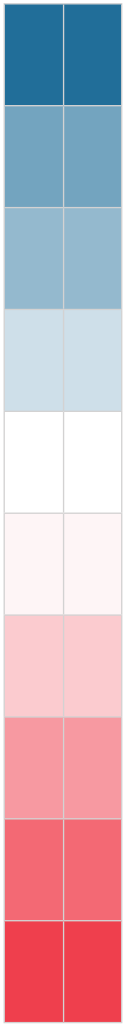
الاسم:

الهدف:

قياس النتائج المبلغ عنها من قبل المريض (**PROM**):

الدرجة:

أفضل ما يمكن



أسوأ ما يمكن

الأمور التي تعوقك:

الخطة:

المتابعة التالية:

مدير الرعاية:

RESOURCE 4:
Baseline PROM Documentation Template

Russian

Дата посещения:

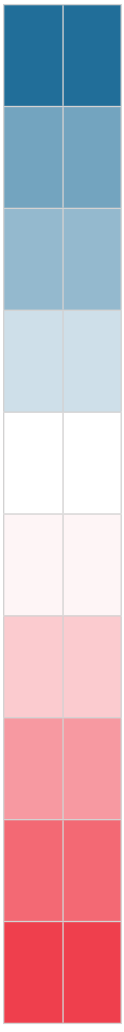
Имя:

МЕСТО ДЛЯ ЛОГОТИПА ВАШЕЙ

Цель:

Анкета PROM: **Балл:**

Наилучший результат



Наихудший результат

Что вас сдерживает:

План:

Последующий визит:

Менеджер по уходу:

Номер телефона:

RESOURCE 5:
Baseline PROM Documentation Template

Simplified Chinese

就诊日期:

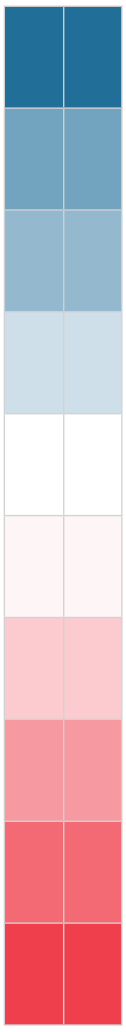
在此处放置公司徽标

姓名：

目标:

最好的可能

PROM： 分数：



是什么原因阻碍了您：

计划：

最坏的可能

下一步跟进：

护理主管：

电话：

RESOURCE 6:
Baseline PROM Documentation Template

Traditional Chinese

就診日期:

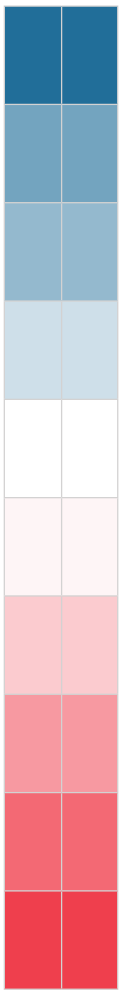
在此處放置公司徽標

姓名：

目標:

最好的可能

PROM： **分數：**



是什麼原因阻礙了您：

計劃：

下一步跟進：

護理主管：

電話：

最壞的可能

RESOURCE 7:
Baseline PROM Documentation Template

Vietnamese

Ngày thăm khám:

Tên:

ĐẶT LOGO CÔNG TY CỦA BẠN Ở ĐÂY

Mục tiêu:

TỪ: **Điểm số:**

Điều gì đang cản trở bạn:

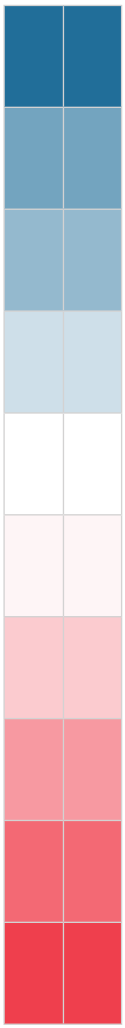
Kế hoạch:

Theo dõi tiếp:

Nhân viên Quản lý Chăm sóc:

Số điện thoại:

Tốt nhất có thể



Tệ nhất có thể

RESOURCE 8:
Role-Play

Practice

- Select one person to role-play the clinician and one person to role-play the individual.
- Choose a case that best fits your care population. Role-play setting the goal and documenting the goal using a PROM and an action plan.
- For the remaining cases, switch roles and repeat the exercise.

CASE #1

Mrs. R is an 89-year-old Mexican, Spanish-speaking (limited English, in Los Angeles since the 1950s), straight female with moderate dementia, with anxiety and nighttime behaviors. Her husband passed away 2 years ago. She needs functional assistance with day-to-day activities. She lives with her daughter, son-in-law and granddaughter. The family is concerned about wandering (a neighbor found her outside the home a few months ago) and falls (the last fall was 1 month ago: she tripped on steps at home and bruised her arm). Mrs. R's daughter, who provides most of her daily care, reports feeling very strained trying to balance her job and taking care of her mother.

Mrs. R used to enjoy going for walks around her neighborhood and to the senior center down the street, but due to her functional limitations and fall risk, she has been unable to do either activity.

CASE #2

Mr. K is a 45-year-old Asian, gay male with metastatic colon cancer, in for a follow-up visit. On his last CT scan, 1 week ago, he had new lung, liver and abdominal metastases. He has an appointment to discuss the findings with his oncologist next week. His husband accompanies him to the visit today, and is tearful in the visit. He is scared that the chemo is no longer working, and is worried about treatment options to his husband.

Mr. K reports worsening nausea and abdominal pain over the last few weeks. He has been using his pain pills and nausea medication more frequently, and missed work last week due to worsening symptoms. He makes service calls for a heating, ventilation and air conditioning company, and is worried about being able to pay his bills if he can't return to work, since his husband is a stay-at-home dad.

There is no advance directive in the patient's chart or on file. The couple reports that they completed a will 10 years ago, after the birth of their third child, but have never completed an advance directive or living will.

CASE #3

Ms. H is a 75-year-old White, lesbian female with severe COPD, on 3L of oxygen at home, in addition to stage III chronic kidney disease and knee osteoarthritis. She is a widow who lives alone. She hired a part-time caregiver (Mon–Fri, 9am-12pm) to help with meal preparation, housework, laundry and transportation. Her appetite is poor; she eats only one meal on most days. She can shower by herself, but worries she will fall. During the day, she watches TV, reads and naps.

She is largely homebound, and has been out of the house only twice in the last several months, due to shortness of breath. She is lonely. She volunteered at a local elementary school library, until about 2 years ago, when her breathing began to worsen. Her son lives nearby and visits most days after work. Her daughter lives out of state and tries to visit once a month.

Ms. H also reports a fall 4 days ago. She lost her balance getting off the toilet. She scraped her left arm on the vanity in the fall and sustained a skin tear, which she bandaged herself at home. She has been using a rollator walker since the fall, and feels more stable with it, but has declined physical therapy because she is very fatigued when leaving her home.

CASE #4

Ms. X is a 43-year-old Black, straight, single female presenting for her intake appointment. She scored 13 on the PHQ-9 (reflecting moderate depression), and is seeking counseling. She is tearful today, as she reports a history of experiencing symptoms of depression and loneliness, but this is the first time she has sought treatment.

Ms. X lives in a 2-bedroom house with her adult son. Ms. X has multiple sclerosis and doesn't drive; her son provides her transportation. Since the COVID-19 pandemic, Ms. X reports that she has stopped going out much and socializing. In that time, her house has become disorganized and cluttered, and the upkeep overwhelms her. When asked about goal setting, Ms. X has several significant changes she would like to make to her life and circumstances, including improving her mental health, socializing more, exercising more and cleaning up her house and other home improvement projects.

CASE #5

Mr. Y is a 35-year-old White, straight male with comorbid alcohol and opioid use disorder, as well as hepatitis C. He is here today for a follow-up appointment. Mr. Y has had past interactions with the justice system as a result of his substance use, and has court ordered requirements to engage in treatment.

Mr. Y is currently unemployed, temporarily lives with his brother and does not have access to reliable transportation. He reports that his involvement with the justice system has made it difficult to obtain employment, and lack of transportation has made it difficult to keep employment. Mr. Y has a young child. He does not have custody, due to his poor relationship with the mother, but says he wants to be more involved in the child's life.

Mr. Y reports that he has been drinking since he was a teenager, and began using opioids in the last 2 years. He has received treatment for his alcohol use, but did not find it helpful. He is resistant to goal setting because he must meet requirements related to his involvement with the justice system.

CASE #6

Ms. Z is a 24-year-old, Hispanic, bilingual (Spanish and English speaking), queer female referred for follow-up services after an ED and subsequent psychiatric inpatient stay for psychosis. Ms. Z had been experiencing delusions and paranoia, expressing that the secret service was planning to kidnap her and take her to Washington, DC. Ms. Z had not been taking any antipsychotic medications or engaging in treatment prior to her most recent hospitalization.

Ms. Z lives with her parents in a two-bedroom apartment. She lives in an urban area, and can walk or use public transportation. She is currently unemployed. She had taken college-level courses, but is not currently enrolled. Ms. Z is resistant to medications; she reports undesirable side effects from the medications she received while hospitalized, and does not want to feel that way again. During the visit, Ms. Z exhibits flat affect while describing her current circumstances, and expresses wanting increased stability and control in her life.

PRACTICE

1. **Identify top values.** Identify and document the individual's values.
    - Connecting with others (friends/family, community, spirituality).
    - Enjoying life (productivity, personal growth, recreation).
    - Functioning (independence, dignity).
    - Managing health (symptoms, quality of life).

2. **Complete the phrase for each value:** The one thing the individual wants to focus on is _____, so they can _____ more often or more easily.

3. **Have the individual decide on ONE goal to work toward and make the goal SMART.**

Document the goal using a PROM. Specify the follow-up time frame. Develop an action plan to help the individual understand their role and the role of the clinician in completing the goal.

Remember, when documenting a goal:

- Is the PROM related to the goal itself or to a barrier to achieving the goal?
- Is the goal SMART (Specific, Measurable, Attainable, Realistic, Time-Bound)?
- Is there an action plan to help the individual reach their goal?

Feeling stuck?

- Link back to values. ***"Can I double check: Is this really important to you?"***
- Is the goal and scaling SMART?
- Take small steps toward a larger goal.
- Encourage supportive language (rather than punitive, self-judgmental language). ***"If you do this, what will be the benefits in the long term?"***
- Anticipate obstacles. ***"What might get in the way of doing that?"***
- Discuss the costs. ***"If you keep doing what you are doing, what will it cost in terms of your well-being?"***
- Recognize that discomfort sometimes comes with taking new steps. ***"Are you willing to feel some discomfort in order to do what matters to you?"***
- Don't allow your mind to bully you into giving up. ***"I'm too tired; I'm too busy; I'll fail."***
- Get support. ***"Maybe ask a friend to walk with you."***
- Use reminders. ***"Set an alarm on your phone or in your calendar."***

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