The usual goal of health care from the provider perspective seems self-evident: identify a problem, prescribe a treatment, await recovery. From the patient perspective, too, the goal can be simple: get better! For much of modern acute-care medicine, this is the most common model of care, and it works well when a problem is readily definable, a treatment protocol is recognized, and the desired outcome is agreed to by all.

However, a different model of care may be better-suited to many patients because it is concerned with chronic conditions that can at best be managed rather than cured. Multiple chronic conditions are common among the elderly, people with disabilities, and even special-needs children. For these patient populations, especially those who are frail and significantly impaired, it may not be so obvious how to prioritize among treatment options or to agree on optimal outcomes. Many providers may be involved, and their directives may not be coordinated or even compatible.

Some physician leaders champion a model known as goal-oriented care. This approach focuses on a patient’s health goals as the impetus for care decisions; looks beyond symptoms to include functional status, social interactions, and patient values; and presupposes a team approach to patient care.

Concept pioneer James Mold, MD, wrote in 1991 that “the process of establishing goals and determining strategies for achieving them, not the identification and resolution of problems, should direct health care.” He noted that problem-oriented care, while suitable to the acute and curable illnesses that represent a shrinking percentage of health care, encourages a view that health simply equates to the absence of disease. Goal-oriented
care, on the other hand, “simplifies decision-making for patients by focusing on outcomes that span conditions and aligning treatments toward common goals.”

The concept of goal-oriented care seems like it would be compatible with recent efforts to make care more patient-centered. In fact, however, it represents a substantial culture change for both providers and patients. Why should this be? Several factors are at work:

- **Communication:** Training for health care professionals tends to emphasize science far more than interpersonal skills. Some providers may view the idea of soliciting a patient’s values and preferences as uncomfortable because it injects concerns over which the provider has little or no control. While many patients might welcome such interaction, others may be reluctant to talk about issues they fear a physician might dismiss or find trivial.

- **Time:** It can be challenging to obtain a history, formulate a diagnosis, and recommend treatment within the typical 15-minute appointment time. Therefore some physicians may not be open to what they see as an additional task, discussing a patient’s goals and developing a tailored care plan, within this time span. And while it’s possible that a team member such as a nurse or a care manager could conduct these conversations, it is unclear how many medical practices are staffed in a way that allows this.

- **Documentation:** Physicians need to document patient encounters, and the electronic health records (EHR) now used by a majority of practitioners frequently incorporate pre-defined templates and data fields for the recording of problems, medications ordered, and actions taken. Documenting goals, preferences, strategies agreed to, and milestones achieved may require significant EHR evolution.

- **Values:** Clinicians and patients may not agree on priorities or basic beliefs. That is, an action that conforms to clinical guidelines may conflict with what a patient wants. For example, a recommended treatment to control blood pressure may have side effects that trouble a patient more than the uncontrolled pressure itself. Further, there may be trade-offs among prescribed treatments for a patient’s multiple chronic conditions. A physician is trained to take action to prolong life, but a patient may choose pain palliation over surgical or chemical intervention. A life goal (say, “I want to make peace with my sister”) that means a great deal to the patient may not relate well to a clinical goal.
• **Family:** Conflict may also arise when the patient’s family has different ideas about the form and magnitude of appropriate intervention than the patient, or even the physician.

Reorienting patients and clinicians to a goal-oriented mode likely will require education on both sides, along with time to develop new care processes and practice supports. New tools may be needed, allowing the care team access to appropriate information and other system supports across an entire population of patients. Ways to measure success, not only to gauge the strength of patient preferences but also the achievement of milestones (even when disease-specific clinical standards are not met), are also needed.

It is not clear how efforts to move toward goal-oriented care may factor into the ways clinicians are evaluated and rewarded on the basis of quality and patient-centeredness. Two approaches being deployed are payment reform and the refinement of quality metrics, both of which have led to some level of dissonance among providers and payers. Increasing accountability for care outcomes has become a mantra, but holding a clinician accountable in terms of compensation can cause tension with respect to who is actually responsible for patient outcomes. For patients with multiple chronic conditions, many physicians (both primary and specialty) are likely to be involved.

At the same time, there is considerable unrest within the physician community regarding the proliferation of quality metrics and the sometimes opaque way they may be used, especially by payers. Efforts by some groups to streamline and standardize measures may ameliorate these concerns, but this will take time. Further, some clinical behaviors are easier to measure and to change than others. Whether aspirin was given or whether a patient’s HbA1c level is below a defined threshold is fairly simple to ascertain and document. But it may be more difficult to determine whether the goals of a patient with multiple chronic conditions were identified and used to drive a care plan—and with what success. Where clinical and functional outcomes represent conscious decisions to accept trade-offs, it will be critically important for these measures to be as transparent as possible.

Various organizations are piloting or implementing some form of goal-oriented care processes with their patients. For example, Dr. Mary Tinetti’s group at Yale is testing a model known as CaRe-Align, designed to facilitate the identification of patient and caregiver goals and preferences and to better align these
within primary and specialty care delivery. The Veterans Health Administration is piloting shared decision-making programs around the country, a number of which are geared to eliciting and acting on patient goals. NCQA (the National Committee for Quality Assurance) is studying the use of a goal-oriented approach to generate greater accountability for bridging medical care and long-term services and supports. The National Quality Forum is engaged in work around quality information for people with complex and chronic conditions, including standards and decision supports for shared decision-making.

SESSION

This Forum session considered several efforts to develop goal-oriented care, the cultural challenges involved in broad adoption of this approach, and the importance of enhancing practitioners’ ability to practice collaboratively. Mary Tinetti, MD, Gladys Phillips Crofoot Professor of Medicine (Geriatrics) at Yale University, described the impetus toward goal-oriented care and what it is hoped can be accomplished through its spread, as well as her own experience in implementing the model. David Reuben, MD, professor and chief of geriatrics at the University of California, Los Angeles, explored means of measuring an objective as complex as goal definition and attainment. Richard Allman, MD, chief consultant in the Office of Geriatrics and Extended Care Services at the U.S. Department of Veterans Affairs, described a number of efforts to implement goal-oriented care for the nation’s veterans and (with VA practitioners paid on salary) the factors other than payment that pertain. Christine Cassel, MD, president and chief executive officer of the National Quality Forum and a geriatrician, talked about the promise of goal-oriented care, the imperative to get measurement right, and NQF’s work in this area.

KEY QUESTIONS

• How does goal-oriented care differ from today’s predominant focus on defining problems and seeking their solution?

• Is goal-oriented care applicable to all, or is it to be targeted principally to people with multiple chronic conditions? How should care delivered in this way be evaluated? That is, can evaluation take into account an assessment of reasonable goal development and progress toward goal attainment, rather than
relying primarily on clinical markers that tend to be defined on a disease-specific basis?

• How can information elicited from patients and caregivers be combined with clinical evidence and used to shape care and maximize goal attainment?

• As providers try to scale this approach to larger populations, what policy and payment levers might be effective? Why will measurement be so critical to facilitate changes in practice and prevent manipulation or “teaching to the test”?

• To what extent are provider organizations, health plans, and government health programs working to support goal-oriented care? What kind of research and infrastructure are they (or could they be) investing in? What role are accountability organizations playing? And foundations? How might further developmental work be supported, and where might coordination between the public and private sectors be warranted?

ENDNOTES
