The *why*, *what* and *how* of goal planning in stroke rehabilitation

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Three inter-related purposes guide our work:
1. Rethinking rehabilitation
2. Embedding person-centredness
3. Making a difference
Goal planning in stroke rehabilitation

01 WHY?

02 WHAT?

03 HOW?
Goal planning in stroke rehabilitation
Goal planning in rehabilitation

“The essence of rehabilitation”
“The cornerstone of effective rehabilitation”
“One of the skills that most specifically characterises professionals involved in rehabilitation”
“A prerequisite for interdisciplinary teamwork”
There is evidence to support the implementation of stroke specific inpatient and community rehabilitation services. The benefit arises when well organised teams, work with the patient and family/whānau to achieve goals.

The benefit derives from:
- Offering timely rehabilitation
- Co-located organised inpatient and community services
- Well organised dedicated stroke rehabilitation teams with regular team meetings
- Skilled stroke rehabilitation therapists
- Goal setting in discussion with the patient/whānau and the interdisciplinary stroke rehabilitation team
- Sufficient rehabilitation intensity to achieve maximum recovery
- Options for community rehabilitation including (but not limited to) early supported discharge
- Staff and patient/family/whānau education
- Services to smooth transition back into the community, including return to work & driving, and
- Regular meetings with patient and family/whānau.

Goal setting in discussion with the patient/whānau and the interdisciplinary stroke rehabilitation team
Purposes of goal planning in rehabilitation

• Multiple (possibly conflicting) purposes
  1. To improve patient outcomes
  2. To enhance patient autonomy
  3. To evaluate outcomes
  4. To respond to contractual / legislative / professional requirements

• One approach is unlikely to achieve all this

(Levack et al. 2006)
So....

• What should be our primary driver for goal planning in stroke rehabilitation?
• How might that inform...
  • What types of goals we set?
  • How we do it?
Stroke rehabilitation in context

• Despite knowledge advance re: effective prevention, treatment and rehabilitation in stroke
  • Efficacy ≠ real world effectiveness
  • The long-term burden of stroke remains significant and is growing

• For many people, rehabilitation requires
  • Intensive effort over long periods of time
  • Sustained engagement is key

• Services largely targeted at acute/subacute phase
  • A strong rhetoric of ‘self-management’ beyond that
Where we tend to focus our energy

Admission - Assessment - Treatment - Discharge

3 weeks

Primary outcome of interest:
Safe to discharge

KPIs:
Length of stay

Impairment
Function
Activities of daily living
But, for the person with stroke...

A life time

Primary outcome of interest: Long term health and well-being

KPIs:
Living a healthful and meaningful life
A shift necessary?

- Acute event
- Self-management
- Long term condition
- Co-creating health
Our primary driver for goal planning in stroke rehabilitation?

- To what extent could our goal planning processes:
  a) Support sustained engagement in a process of recovery?
  b) Build capability for long-term health and well-being?

- And in doing so.... have therapeutic potential in their own right?
Goal planning in stroke rehabilitation

To:

a) create the context for sustained engagement
b) build capability for future health and well-being
Goal planning in stroke rehabilitation

WHY?

01

WHAT?

02
A helpful starting point?

**Self-regulation Theory**

- Most human behaviour is goal-directed
- People strive towards multiple goals
- **Success in achieving desired goals is determined by one’s own skill in regulating cognition, emotions and behaviour**
- Progress or failure in goal attainment has affective or emotional consequences
- Goal attainment, motivation and affect closely related and will interact

(Siegent, McPherson & Taylor, 2004)
Consider this in the context of stroke
Self-regulation Theory

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(Siegert, McPherson & Taylor, 2004)
So....

• If we want to:
  a) create the context for sustained engagement
  b) build capability for future health and well-being

• Our goal planning processes need to support self-regulatory skill development
SMART goals – prevails as the dominant approach?

- S – Specific
- M – Measurable
- A – Achievable
- R – Realistic
- T – Timebound

Evidence for SMART?
Surprisingly weak - except for ‘specific’
Challenging the principles of SMART

- **S** – Specific
- **M** – Measurable
- **A** – Achievable
- **R** – Realistic
- **T** – Timebound

Do goals need to be (A) achievable?  
...or does progress towards a demanding goal (while not necessarily attaining it) bring about positive outcomes and help patients/clients become more involved in the process?  

Do goals need to be (R) realistic?  
...or do aspirational goals play an important part in sustaining motivation to keep striving and working at rehabilitation?  

Do Goals need to be (T) timebound?  
...or does a fixation on short term achievement impact negatively on long term recovery and adaptation?
SMART goals

• S – Specific
• M – Measurable
• A – Achievable
• R – Realistic
• T – Timebound

Do not necessarily....
...create the context for sustained engagement
...build capability for future health and well-being
Why?

• Tend to reflect disciplinary-specific or service-centred goals, versus personally meaningful goals
  • Focus on ‘realistic’ and ‘achievable’ versus ‘hope’ and ‘challenge’
I remember the first time the therapist at the hospital talked about setting goals, I said something about tramping again, perhaps swimming, perhaps even playing golf again. She said – “what about getting up in the morning and getting dressed?” – and I thought hell’s teeth, we’re on a different page here and my heart sank a bit.

(Person w Stroke)
Why?

• Tend to reflect disciplinary-specific or service-centred goals, versus personally meaningful goals
  • Focus on ‘realistic’ and ‘achievable’ versus ‘hope’ and ‘challenge’
• Specific to a discrete episode of care – frequently just a small part of the patients rehabilitation journey
Admission Assessment Treatment Discharge

e.g.

3 weeks

Impairment
Function
Activities of daily living

Primary outcome of interest:
Safe to discharge

KPIs:
Length of stay
Why?

- Tend to reflect disciplinary-specific or service-centred goals, versus personally meaningful goals
  - Focus on ‘realistic’ and ‘achievable’ versus ‘hope’ and ‘challenge’

- Specific to a discrete episode of care – frequently just a small part of the patients rehabilitation journey

- Emphasis on goal characteristics (not goal-directed behaviour)
  - Unlikely to build self-regulatory skill
SMART goals

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• T – Timebound

But, if not SMART, then what?
Person-centred rehabilitation

Co-constructing stroke rehabilitation: study exploring the impact of engagement on rehabilitation outcomes

Felicity A Bright1, Nicol Christine Cummins1, Lixin and Kathryn M McPherson2

Abstract: Objectives: To explore how practice influences patient care and engagement in rehabilitation. Design: A qualitative study using focus groups and observations. Setting: Inpatient and community. Subjects: Eighteen people experienced in rehabilitation. Interventions: Not applicable. Results: The practitioner's engagement with the patient was important for rehabilitation outcomes. When practitioners were engaged, the patient's engagement was enhanced, but engagement was absent, patient engagement was low. Disengagement was taboo outcomes, or when having anemic influences, the practitioner's engagement was not reported by patients.

Keywords: Patient participation, engagement

Hope in people with aphasia

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Background: Hope is considered important for health, recovery, and rehabilitation outcomes in patients with aphasia. Little is known about how people in follow-up stroke rehabilitation engage in rehabilitation. The purpose of this study was to explore how hope was experienced by people with aphasia following stroke rehabilitation.

Methods/Procedure: This study employed qualitative interview methods. Data were collected through unstructured interviews with five people with aphasia. Supported conversation techniques were used to facilitate full participation of participants. Data were analysed using a number of approaches – coding, theming analysis, narrative construction, diagramming, and mapping.

Conclusions: Behavioural strategies

Hope is said to be important in rehabilitation and living with illness or injury (Barker & Blaser, 2005; Benson, 2001; Donnell, 2004; Gunv, Snyder & Duncan, 2006; Luthie & Severinson, 2004; Nekulich, 1999; Speroff, 2001). It is commonly considered a multidimensional concept (Dafour & Martini, 1985; Paran & Popovich, 1999; Morse & Dobroczek, 1995).
Meaningful goals

- A personalised approach to goal planning
- Explicitly targeted at building self-regulatory skill and capability
- An intervention vs. a means to an end
Goal planning in stroke rehabilitation

To:

a) create the context for sustained engagement
b) build capability for future health and well-being

Move beyond SMART to Meaningful goals
Goal planning in stroke rehabilitation

01 WHY?

02 WHAT?

03 HOW?
Goal MAP

Identifying what matters most
Anchor concrete actions, goals, tasks of therapy to what matters most
Planning to support implementation of goals into action

Meaning
The why?
M

Anchor
The what?
A

Planning
The how?
P
Step 1: Meaning

• Prioritising therapeutic relationship
• Knowing what matters as the context for goal-related activity is a powerful tool
• The most adaptive form of self-regulatory behaviour relate to the ability to:
  • select concrete, manageable goals (lower order tasks)
  • that are linked to personally meaningful (higher-order) representations

Emmons (1996)
The critical points?

• Focus on
  • Getting to know
  • Broader hopes and aspirations

• Encourage people to move beyond impairment or to articulate vague goals in more detail
  • E.g. “I just want to walk again”, “I just want to get better”

• Helping people to move beyond the ‘what’ to the ‘why’?
  • E.g. “I just want to drive again”
Step 2. Anchor

• Anchor goals, tasks and activities (explicitly) to what matters most
  • A tool for making sense of therapy
• Negotiate levels of progress towards attainment
  • Links to mood/motivation/sense of self
• Modelling a strategy for the clients continued use
Higher order hopes

Broad
Abstract
Conceptual
Linked to desired self-image

Concrete
Manageable
Lead to achievement of higher order goals

Lower order goals

(Siegert, McPherson & Taylor, 2004; Emmons, 1996)
To be the best Nana I can be

- To be able to knit my mokopuna a jersey
- To be able to knit a small item without any help
  - Upper limb function
  - Fatigue
  - Communication
  - Cognition
- To be able to take my mokopuna out
  - Fatigue
  - Organisation and pacing
- To be able to look after my mokopuna
  - Fatigue
## Negotiating levels of goal progress

<table>
<thead>
<tr>
<th>To be the best nana I can be</th>
<th>Fantastic outcome</th>
<th>Great/ better than expected</th>
<th>Expected outcome</th>
<th>Current level</th>
<th>If things got worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to knit my mokopuna a jersey</td>
<td>Able to hold a knitting needle and make a small item without any help</td>
<td>Able to hold a knitting needle and make some stitches with a little bit of help</td>
<td>I can’t hold a knitting needle</td>
<td>Not able to do anything for or with my mokopuna</td>
<td>Not able to do anything for or with my mokopuna</td>
</tr>
<tr>
<td>Able to take my mokopuna out for a treat</td>
<td>Able to look after my mokopuna for an afternoon</td>
<td>Able to enjoy having my mokopuna come for a visit</td>
<td>I can only cope with having my mokopuna around for a few minutes and I don’t enjoy it</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• Explicitly link broader hope to the tasks and goals of rehabilitation
• Negotiate goal levels to allow for a sense of progress and experience of success
• Use the clients words where possible
Step 3. Planning

• Action and coping plans to support goal-related activity
• We all have good intentions – some of mine...
  • I’m going to exercise more
  • I’m going to eat breakfast
  • I’m going to manage my work-life balance better
• BUT often a gap between what we intend to do – and what we actually do
  • The Intention-Behaviour Gap
Intention-behaviour continuity

- Continuity between intentions and action only holds when:
  - The behaviour in question is discrete not repetitive;
  - The behaviour is fully under the control of the individual;
  - The costs and benefits of the behaviour occur at the same point in time allowing for equal temporal weighting

(Hall et al 2008)
Planning for action

- Translating intentions into action needs explicit management
  Gollwitzer and Sheeran (and others)

- Rehearsal of ‘specific’ plans = more likely the intention will be implemented
  - ‘If-then’ plans
If-then plans

Failing to get started (Action plan)

If it is 9am on Tuesday or Thursday, then I will walk to the end of my street & back

Getting derailed (Coping plan)

If it is raining when I am meaning to go for a walk, then I will drive to the local shopping mall and walk from the supermarket to my favourite clothes shop and back again

Negative states (Coping plan)

If I start to feel anxious about going for a walk, then I will remind myself that in the past walking has made me feel good
Goal MAP in summary

Identifying what matters most

Anchor concrete actions, goals, tasks of therapy to what matters most

Planning to support implementation of goals into action

Meaning M

The why?

Anchor A

The what?

Planning P

The how?
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Meaning M
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The why?
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