It can be challenging for GPs to find the best approach to providing care for patients with multiple medical conditions (multimorbidity). Most care focusses on the management of single diseases yet adopting a patient-centred focus may be better for patients with multimorbidity. This is encouraged in recent health policy and guidance. However, it is not always clear how this should be put into practice. This article describes how GPs might use 'goal-setting' during consultations with patients with multimorbidity, to help achieve more effective care that is better suited to patient's needs.

The GP Curriculum and goal-setting for patients with multimorbidity

Life-stages topic: people with long-term conditions including cancer

The role of the GP in the care of people with long-term conditions is to:

- Work with patients, their families and carers in a collaborative manner that supports patient activation; encouraging individuals to develop the knowledge, skills and confidence to take an active role in their own self-care
- Work collaboratively with people living with long-term health conditions to agree goals, identify support needs, develop and implement plans, and monitor progress
- Move away from a disease-based model of care towards a person-centred system that takes a biopsychosocial approach, considering each person and their family holistically
- Involve the whole Multi-Disciplinary Team (MDT) to facilitate person-centred approaches to care, including the systematic gathering of information about an individual's personal experience of living with their conditions and an organisational approach to collaborative care and support planning
- Proactively encourage lifestyle changes that will reduce the risk of other health problems in those who have already developed long-term conditions, cancer or multi-morbidity.

The RCGP curriculum life-stages topic guide details specific knowledge and skills related to multi-morbidity. This article will cover the following areas:

- Reducing the burden of multi-morbidity and treatment, including appointments, on the quality of life of the patient and their carers/family
- The patient's needs, preferences, priorities and goals including the role of carers and family
- Providing whole person care taking into account a patient's social, mental and physical wellbeing
- The benefits and risks of guidelines addressing single health conditions
- The benefits of an agreed personalised management plan to coordinate care

The population of the UK is ageing, and multimorbidity, the co-occurrence of two or more long term conditions, is more common in older people. At present around 8 million people aged over 65, along with a significant proportion of younger adults, live with multimorbidity in the UK (Barnett et al., 2012). It is estimated that around four out of five consultations in general practice will involve a patient with multimorbidity (Salisbury et al., 2011).

The prevalence of multimorbidity is a problem, as it is associated with a worse quality of life and health outcomes, as well as higher costs for the NHS. It often results in polypharmacy (concurrent use of five or more medications), with a subsequent burden of treatment and the risk of adverse drug events (Masnoon et al., 2017). Around 6% of hospital admissions are related to medication adverse events, with higher rates for older people (Pirmohamed et al., 2004).

What happens now?

Despite the fact that most primary care consultations involve patients with multimorbidity, the present approach to care still tends to focus on management of single diseases. This is driven by factors including the current structure of the heath service (with ever-increasing specialisation) and research often taking place within disease-based areas. This manifests in initiatives such as Quality Outcomes Framework (QOF) and the proliferation of single-disease guidelines. Bodies including the National Institute for Health and Care Excellence (NICE) have recognised this failing and have issued their own guidance for the management of multimorbidity (NICE, 2016), however many GPs are still performance managed through QOF and other policies that encourage care that focuses on attainment of single-disease biomedical markers.

GPs also often struggle with these consultations due to the complexity of the patient's problems, and a lack of time and resources to fully explore all of the patient's issues. This can frequently result in the balance of power being swung towards the GP throughout the consultation, as they try to retain control of the agenda in order to keep to time and within familiar territory.

Compounding the problem, most standard consultation models used in medical training tend to presume that the doctor will reactively deal with individual problems presented by the patient. GPs are not routinely trained in methods that have been designed to proactively manage a patient who has multiple interconnected problems.

Continuing to manage this group of patients using the current approach is risky. Diseases or conditions can interact, as can the medications that are prescribed for each. Consider a patient with hypertension and osteoporosis; they may successfully achieve a low blood pressure, but not without the risk of their medication causing hypotension resulting in a fall and hip fracture. Significantly, this approach also risks ignoring the issues that matter most to patients, which are more likely to centre on aspects of their day to day functioning than biomedical markers of disease.

How might we do things differently?

It may be better to dedicate the necessary time and resources to proactively care for complex patients and take a more individualised approach to their health care. NICE acknowledges that not all single-disease guidance will be relevant to each patient, but this is not always recognised in practice. The guidelines should be interpreted on a case by case basis, used as a guide that also takes into account factors such as the patient's co-morbidities, the position of the patient on a particular disease trajectory, the range of medications the individual takes, personal circumstances and approach/attitude to life and health. Crucially, the balance of power needs to be shifted towards the patient so that they have the opportunity to shape their care around what matters most to them. This much more individualised approach is advocated in the NICE guidance, which encourages 'people with multimorbidity to clarify what is important to them, including their personal goals' (NICE, 2016). The sharing of realistic goals by doctors and patients is also core to the Ariadne principles for handling multimorbidity in primary care (Muth et al., 2014), and the General Medical Council's (GMC) new guidance states that medical graduates 'must be able to recognise the goals and priorities of patients' (GMC, 2018). However, at present we do not know the best way to get the recommended approaches for establishing patient priorities into practice.

Goal-setting

One approach that could be a useful tool for GPs to facilitate a more patient-focused consultation is goal-setting. This is not a new concept; it has been widely used in many contexts, including in health care specialties such as mental health or allied health professions such as physiotherapy or occupational therapy. However, it has rarely been used between GPs and patients during routine consultations.

Goal-setting is a process that involves the patient and health professional first establishing and agreeing a number of realistic health and wellbeing goals, then negotiating and agreeing an action plan for achieving these, with a review of goal attainment after a set period. It is particularly helpful in the context of multimorbidity as it is more likely to result in focusing on what really matters to the patient and away from a more disease-centred medical agenda, whilst still allowing the doctor to work in partnership with the patient. It allows the doctor and patient to work together to pro-actively create a plan of care.

If doctors and patients with multimorbidity work together towards goals that really matter to patients this can improve self-management (Coulter et al., 2015). It may also help to reduce polypharmacy, adverse effects, hospital admissions, and costs through increased patient self-efficacy, whilst improving treatment concordance and encouraging earlier appropriate contact with primary care (Coulter et al., 2013).

Many methods involving goal-setting have been described and one of the simplest of these is Goal Attainment Scaling (GAS), as described by Turner-Stokes (2019). A recent study has shown that the use of a goal-setting tool developed from GAS for use in primary care is feasible and effective in consultations with patients with multimorbidity (Ford et al., 2019; Salter et al., 2019). Box 1 outlines the modified version of GAS that was used by GPs and patients in this study.

Box 1: Using Goal Attainment Scaling (GAS) in GP consultations (Ford, 2018)

Goal Attainment Scaling (GAS) is a method of scoring the extent to which patient's individual goals are achieved in the course of an intervention. The most important step is the patient and health professional working together to agree clearly defined goals for treatment, before starting treatment. The goals should be SMART (Specific, Measurable, Attainable, Realistic/Relevant, and Time bound).

When the patient is later reviewed, his or her progress towards attainment of the goal/s can be evaluated and scored using a 6-point scale:
+4. Attained a lot more than expected
+3. Attained a little more than expected
+2. Attained as expected
+1. Partially attained
0. No change
-1. Got worse

In the GoalPlan study GAS was integrated into a patient-focused consultation that involved the patient and GP working in partnership to agree an action plan to achieve the goals.

Practical steps

Goal-setting is likely to be of greatest use in more complex patients with multimorbidity, particularly at times when a pro-active care plan is required. In this section the article will discuss how to identify the sort of patients to consider for this approach, how to plan and prepare for the consultation, and the steps to take during the consultation itself. It will conclude with a discussion of the review appointment. Box 2 provides example phrases for each of the steps that occur within the consultation, and Box 3 uses a fictional case study to illustrate how the steps might occur in practice.

Box 2: Example phrases for steps of the consultation

Preparation
"How are you feeling about setting some goals; would you like anyone else involved?"
"Do you want me to explain anything about why you've been invited to set goals?"
"I'd like to establish what matters most to you to make sure your care is based on that"

Eliciting and legitimising goals
"Have you had any thoughts about what your goals might be?"
"You may have several goals, if you tell me about them perhaps we can identify the most important one for you at this time?"
"That is an important goal to discuss, were there any other goals that you have thought about / written down?"
"What is the most important goal for you?"
"What would you like to achieve over the next few months?"
"Why is that goal important to you?"
"Tell me a bit more about how you feel about that goal?"

Action planning
"Now that we have agreed on your goal(s), we will now spend more time on what to do next."
"We need to talk together about how we make this goal measurable, in other words quite specific so that we know whether you have met it when we meet in [x] months' time"
"There is more than one way to deal with this issue; what thoughts have you had?"
"Just so we are both clear about that goal, how do you see us achieving it?"
"That's given us/me an idea of the things that are important to you, perhaps we could discuss each one of them and we can have a think about how we can work towards those together"
"What thoughts have you had on any steps you / we can take to achieve this goal?"

What to say if options are:
- Similar: "Both options are very similar and involve..."
- Different: "These two options are different and will have different impact on you and your family, let's think what they involve."

"I will try and give you an idea of the likelihoods of each of these risks and benefits."
"We have gone over the options/goals, what they entail and the pros and cons of each. I already have some ideas about what matters to you but let me check – what is the most important issue for you in all this?"
"Have you had a chance to consider these options, from your point of view, in terms of what is important to you?"
"So, what are you thinking at this stage?"
"You seem to have been able to decide on the option that is best for you, are there any final concerns or questions that you want to ask?"

Concluding: summary and evaluation
"How are you feeling about the plan we have made today?"
"So, in summary do you have any final thoughts about the goal(s) you have set and the steps you / we are planning to take to achieve it?"
"Just before we stop is there something else that has occurred to you as we have been talking?"
"Have we missed anything? Do you have any questions about what we have discussed"?
"Let's meet again specifically to see how you / we have been able to work towards them"

Box 3. Case Study.

Patient selection
Dr H recently struggled to get through a medication review with Mr B, an 81-year-old widower prescribed 15 medications. He frequently attended the surgery.

Planning the consultation
Dr H called Mr B to offer him a 20-minute appointment to proactively discuss his care. Mr B thought this would be helpful. Dr H posted him a leaflet to help him consider his goals.

Patient preparation
At the appointment Dr H checked Mr B understood the purpose of the consultation. Mr B replied he did and that he had been chatting to his daughter about it. They had made a list of three goals, with a few ideas about how these might be achieved, making notes on the leaflet Dr H had sent.

Eliciting and legitimising goals
Dr H looked at the leaflet. Mr B had written:
1. Try to eat a bit better as I am losing weight. Maybe I could see someone about what I eat?
2. I want to have less tablets and inhalers.
3. It would be nice to get out a bit more. I don't have my driving licence now - maybe I could get buses?

Dr H asked Mr B to tell her more about the goals. Mr B explained he had been lonely since the death of his wife. He was not eating a lot as he was not inclined to cook for himself, his mood was low and he had little appetite. He did not like having to take lots of medications. He wondered if they were affecting his appetite and mood, and he also worried about forgetting to take them and so avoided going out when they were due.

Action planning
Mr B and Dr H agreed the biggest goal for Mr B was to see people and get out more, as this could make him feel brighter and he may eat more when with others. They agreed this might mean altering his medication regimen, given his anxiety about missing doses. They formulated two 'SMART' goals:
1. By 3 months I want to be having a trip out and cooking a meal for myself at least once a week.
2. By 3 months I will either not be taking any lunch time medications or I will use something to help me remember my pills.

Dr H and Mr B negotiated a plan for Mr B to see the practice's Clinical Pharmacist for a medication review, and a Social Prescriber for advice about local day centres and befriending schemes. They incorporated Mr B's idea of alternative transport (a taxi to take him to a day centre). A record of the goals and plan was made in the notes and a copy was given to Mr B.

Concluding
Mr B and Dr H agreed to meet to review progress in 3 months. Mr B was advised to come in for usual care in the meantime.

Review appointment
3 months later Mr B returned. After his review with the Clinical Pharmacist he had stopped one of medications and another was reduced to twice daily dosing. This gave him the confidence to start going to the church day centre that the Social Prescriber had told him about.

Mr B scored his goal attainment with Dr H. He had done better than expected (score +3) for reducing his lunchtime medications as he had also stopped one. He only partially attained his first goal (score +1), as he was doing little cooking at home. However, he ate a meal every day at the day centre, his mood was brighter and his appetite had improved. Moreover, he was motivated to continue working on this goal.

Patient selection

Prior to conducting the consultation it is important to identify patients who are most likely to benefit from use of a goal-setting approach. Whilst goal setting may suit many types of patient, helpful identifiers of more complex patients with multiple morbidity include: patients who are prescribed five or more medications, those who you think are frail (or are identified by practice search tools such as the electronic frailty index (eFI) as frail), those who are frequent users of health services or simply those with two or more conditions. It is worth noting that although many of these patients will be elderly, such criteria often also apply to younger adults.

Planning the consultation

To use goal-setting effectively it is best to arrange a dedicated 20-minute appointment with patients who have been identified as most likely to benefit. Patients should be made aware that the appointment is intended to involve a proactive discussion about their care, and ideally they should arrive for the consultation having already identified some goals that matter to them. This could be achieved by offering them a simple leaflet to encourage them to think about their goals, sending it electronically, by post or supplying it by hand at a prior consultation. It can help if the patient writes the goals and any plans to achieve them down, bringing this along to the appointment. They should also be encouraged to discuss their goals with relevant family, carers or friends, and they should be encouraged to attend the consultation with these individuals if they wish.

Patient preparation

Successful goal-setting requires both GP and patient to be prepared, both prior to the consultation (as described above) and through an initial preparatory stage within the consultation. This is an important step in ensuring a patient-focused consultation, enabling patients to feel empowered to share what matters with their GP. It should involve the GP first checking the patient's understanding of goal-setting and establishing the degree of preparation that he or she has made. Ideally the patient will supply completed pre-consultation paperwork (if they have been offered a leaflet to help them think about their goals), or at least refer to it. It is helpful if the patient also indicates if they have discussed their goals with family or friends. Through this process the GP and patient together establish the agenda of the consultation. The consultation moves on from this stage by the GP encouraging the patient to lead and initiate a discussion about their goals and priorities. Example phrases that GPs might use in this stage of the consultation are shown in Box 2.

Empowering patients to take more control is not always easy but is important in patient-centred care. If a patient has not thought about their goals in advance of the consultation more time will be required to establish priorities and discuss potential goals. In addition, being put on the spot to come up with goals may mean a patient has not had time to really reflect on what matters most to them. This risks the goals being more likely to be produced and driven by the GP, and thus less likely to result in self-motivated behaviour change with consequent health benefits.

Some patients will find it much harder to prepare for a goal-setting consultation, e.g. those who are carers for others may find it hard to focus on themselves. They may need more support and encouragement.

Eliciting and legitimising goals

The next critical step of the consultation is to elicit the goals that are most important to the patient, seeking to understand the reasons why they matter. This generally requires the GP to first listen actively and without interruption so that the patient can talk openly about what is important to them and why. The GP should be alert to cues, to later pickup and explore. GPs should direct the discussion to fully explore the patient goal/s and personal circumstances, in order that they can help

the patient choose the most appropriate goal/s and together formulate the best plan of action to meet them.

This stage also has a very important role in encouraging patients to self-manage their conditions. Through active empathic listening the GP often legitimises the patient's goals, supporting and validating the patient's views of their importance. Through endorsing the importance of the goal and encouraging its discussion the GP helps the patient consider the steps that they can take in achieving it. This technique is also used in motivational interviewing (when trying to create behaviour change in an individual), and research has previously shown it can increase the likelihood of patients engaging in self-management (Coulter et al., 2015).

Action planning

Collaborative action planning is fundamental to supporting patients to turn priorities and preferences into achievable goals. It requires the patient and GP to work together to first establish how to make the identified goal/s SMART (Specific, Measurable, Attainable, Realistic/Relevant, and Time bound), and then deliberate on how they will work in partnership to attain them. When doing this it helps if the patient can describe their own thinking on steps to take to achieve the goal, as this helps make sure that he or she maintains ownership of the action plan.

Choices should be discussed by both parties to explore and set goals, with the pros and cons of options discussed in partnership. This process of collaborating to co-produce realistic and measurable goals and action plans involves the skills of shared decision making. Some useful phrases that may be used when sharing decisions with patients can be found in Box 2.

Ultimately an informed action plan is negotiated. The GP and patient finish this step by recording the goal/s and the current level of attainment, so that they can rate progress towards attaining the goal at the review appointment. It is also helpful to record the goals and action plan in the notes, sharing them with other members of the health care team. This is important as often the goals that patients set will require input from different team members.

Concluding the consultation

Finally, it is important to conclude by summarising the goals that have been agreed, and the agreed plan of action. This allows any outstanding points or misunderstandings to be clarified. A timeframe should also be agreed for when the GP and patient will meet again to review the patient's progress. This timeframe will depend on the goals that have been set but generally a few months is a realistic review point for most.

Review appointment

Reviewing goals is an integral part of the process of goal-setting. It involves the patient and GP meeting to discuss and review the goals that have been set, as well as the plan put in place to meet the goal. Patients living with long-term multiple conditions often face continuous change in their health and wellbeing. Therefore, this review process might best happen after an agreed time period (e.g. 3 months). It might also happen concurrently alongside other points of contact with the practice - another reason for documenting the goals so they are shared with the practice team.

At the review an evaluation needs to be made to determine whether the patient has stayed the same in terms of their level of attainment, or achieved more or less than intended. It may be helpful to explore the reasons for achieving particular levels of attainment. Understandably, patients will vary in their achievement of goals. Some goals may change over time with life circumstances, whilst others may become redundant or simply unattainable. However, the process of goal-setting can be

valuable and therapeutic in itself, through simply motivating the patient and shifting the focus of the consultation towards what matters to them the patient can find the process beneficial.

Conclusions

Goal-setting with patients with multimorbidity is an effective tool for helping GPs achieve a patient-centred consultation with pro-active care planning. The crucial steps in the process are making sure that the GP and patient are sufficiently prepared, the GP takes time to properly elicit and legitimise the patient's goals, and finally the GP and patient work collaboratively to plan how the goals will be achieved. The GP and patient need to remain engaged in the process throughout (see figure 1).

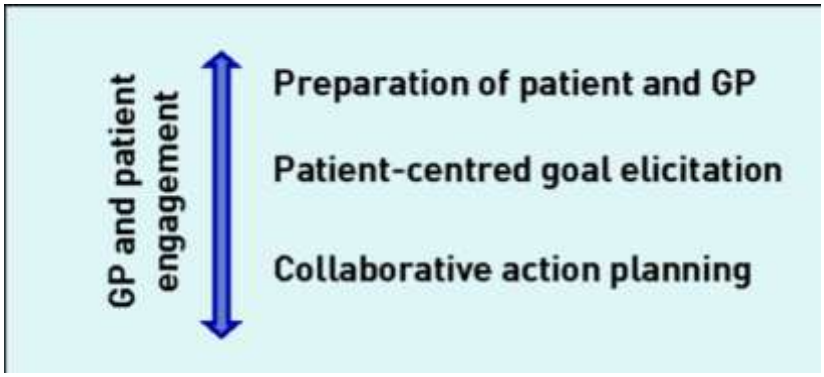

Figure 1. A model for effective goal setting.

Goal-setting is likely to require a slightly longer consultation, plus some time may be needed to review patient notes prior to the consultation and make referrals after. However, if the consultation is with a GP known to the patient the preparation time will be less. Moreover, although evidence regarding whether this approach reduces reconsultation rates is not yet available, it would be anticipated that through providing better management and meeting patients needs it may ultimately save GP time.

The approach could also be used by other members of the primary care team, but given the heterogeneity of goals - some of which will require management decisions that can only be made by doctors (e.g. stopping medications) - it may be more time efficient for GPs to lead on this during pro-active care planning consultations. It also requires the use of advanced communication skills; resources exist to facilitate training in this area (e.g. the 'GP Goal Setting Training' course hosted by FutureLearn: https://www.futurelearn.com). The time and effort required to invest in this approach may be worthwhile, given the increased satisfaction and benefit it can offer both GPs and patients.

Key Points

- Many patients live with multimorbidity and may not be well served by a health system set up to manage single diseases; they may do better with care focused on patient priorities.
- Goal-setting is a method for eliciting patient priorities and planning actions to achieve these goals, it has been used effectively in allied health disciplines in the past and recently successfully trialled in primary care.
- Important steps in goal-setting are: preparation, eliciting and legitimising goals, and collaborative action planning.
- Goal-setting can be effective as a tool for motivating patients to self-manage conditions or make changes to their lives, even when goals are not attained.

References

Barnett K, Mercer SW, Norbury M, et al. (2012) Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *The Lancet* 380(9836): 37-43. DOI: 10.1016/S0140-6736(12)60240-2.

Coulter A, Roberts S, Dixon A (2013) Delivering better services for people with long-term conditions: Building the house of care. King's Fund, London, UK.

Coulter A, Entwistle V, Eccles A, et al. (2015) Personalised care planning for adults with chronic or long-term health conditions. *Cochrane Database of Systematic Reviews* 3(3): CD010523. DOI: 10.1002/14651858.CD010523.pub2

Ford JA, Lenaghan E, Salter C, et al. (2019) Can goal-setting for patients with multimorbidity improve outcomes in primary care? Cluster randomised feasibility trial. *British Medical Journal Open* 9:e025332. DOI: 10.1136/bmjopen-2018-025332

General Medical Council (2018). Outcomes for Graduates. General Medical Council, London, UK.

Masnoon N, Shakib S, Kalisch-Ellett L, et al. (2017) What is polypharmacy? A systematic review of definitions. *BMC Geriatrics* 17(1): 230. DOI: 10.1186/s12877-017-0621-2

Muth C, van den Akker M, Blom J, et al. (2014) The Ariadne principles: how to handle multimorbidity in primary care consultations. *BMC Medicine* 12 (1): 223. DOI: 10.1186/s12916-014-0223-1

National Institute for Health and Care Excellence (2016). Multimorbidity: clinical assessment and management NG56. National Institute for Health and Care Excellence, London, UK.

Pirmohamed M, James S, Meakin S, et al. (2004). Adverse drug reactions as cause of admission to hospital: prospective analysis of 18 820 patients. *British Medical Journal*. 329(7456): 15-9. DOI: 10.1136/bmj.329.7456.15

Salisbury C, Johnson L, Purdy S, et al. (2011). Epidemiology and impact of multimorbidity in primary care: a retrospective cohort study. *British Journal of General Practice* 61(582): e12-21. DOI: 10.3399/bjgp11X548929.

Salter C, Shiner A, Lenaghan E, et al. (2019). Setting goals with patients living with multimorbidity: qualitative analysis of general practice consultations *British Journal of General Practice* 69(684): e479-e488. DOI: 10.3399/bjgp19X704129

Turner-Stokes, L. (2019). GAS – Goal Attainment Scaling in Rehabilitation. Available at: www.kcl.ac.uk/cicelysaunders/resources/tools/gas (accessed 6 September 2019)