Patients’ Perspectives on the Self-Identified Goals Assessment

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OBJECTIVE. The purpose of this study was to investigate patients’ perspectives of the validity of the Self-Identified Goals Assessment (SIGA), which is designed for use by occupational therapists working in subacute rehabilitation and skilled nursing facilities. The SIGA has two primary purposes: (a) to help the patient identify personally meaningful occupational goals to be addressed in therapy and (b) to evaluate changing levels of patient-defined success in desired occupations.

METHOD. Participants (20 women, 10 men) were patients with varied diagnosed conditions at a hospital-based subacute facility. Their mean age was 73.4 years (SD = 12.2). The SIGA was administered by the patients’ regular occupational therapy practitioner after admission and before discharge; a graduate student followed up each administration of the SIGA by asking participants fixed-alternative and open-ended questions about the usefulness of the assessment. Fixed-alternative questions were analyzed as simple dichotomies, and open-ended questions were analyzed through categorization into convergent and divergent themes across participants.

RESULTS. Twenty-nine of the 30 participants confirmed the personal meaningfulness of goals identified in the SIGA admissions interview, and 28 reported that they thought the SIGA helped the therapist realize what was personally important to them. On admission, 9 participants reported difficulty quantifying their performance on the 0-to-10 scale; however, 27 reported that their scores were accurate self-assessments. Participants’ perspectives of the SIGA tended to be particularly positive at discharge.

CONCLUSION. Given the lack of efficient, structured approaches to the measurement of self-identified goals in subacute and skilled nursing facilities, the SIGA tentatively is recommended for use in these settings, pending future research.

The Self-Identified Goals Assessment (SIGA) is a new occupational therapy assessment for use in subacute rehabilitation and nursing homes. The SIGA is designed to help patients identify meaningful goals for therapy and make judgments about progress toward those goals.

Active patient participation in the occupational therapy process is important for several reasons. First, self-determination is an ethical principle in health care. For example, the Occupational Therapy Code of Ethics (2000) state, “Occupational therapy practitioners shall collaborate with service recipients or their surrogate(s) in setting goals and priorities throughout the intervention process” (p. 614). Second, regulatory agencies and accrediting organizations require active participation of patients in goal setting and intervention planning (Commission on Accreditation of Rehabilitation Facilities, 1997; Health Care Financing Administration [HCFA], 1995, p. 5-3; Joint Commission on Accreditation of Healthcare Organizations, 1997). Third, active involvement in goal setting may...
enhance the processes of therapy and, hence, the patient's overall outcome. Pollock (1992) theorized that the patient's active involvement in goal setting enhances motivation for participation in therapeutic processes; the person assuming responsibility for his or her own health is much more likely to rise to the difficult challenges of therapy than the person who is treated as a passive recipient of care. Hocking (2001) concluded from a review of the literature that "evaluations that do not focus on the occupations that clients find problematic will not communicate the purpose of occupational therapy to clients or colleagues and, thus, will contribute to confusion and dissatisfaction with occupational therapy services" (p. 463). Kiellhofner (1995) stated:

Occupational choices are essential since they are the processes of commitment by which persons sustain themselves in a course of action over time. Therapists can enhance a patient's experience with making choices by both providing opportunities for and supporting choices. (p. 266)

Principles applied in the development of the SIGA include (a) consistency with the Conceptual Framework for Therapeutic Occupation (CFTO; Nelson, 1994, 1996) and with traditional principles of occupational therapy (Moyers, 1999; Nelson, 1997); (b) principles of measurement validity; and (c) practicality within the regulatory and administrative constraints of U.S. settings for subacute rehabilitation, which include assigned subacute beds in skilled nursing facilities (SNFs) and hospitals. The SIGA is part of the Melville-Nelson Occupational Therapy Evaluation System for Skilled Nursing Facilities and Subacute Rehabilitation, the current version of which is available on the World Wide Web (Melville & Nelson, 2001). Other sections of this overall evaluation system include assessments of basic self-care; instrumental occupations of daily living; sensorimotor, cognitive, and psychosocial component abilities enabling occupational performance; and prehospitalization status.

Theoretically within the CFTO, two major ways exist to evaluate the success of a person's occupation: objectively and subjectively. Objective success is defined as occupational performance and impact that match the sociocultural criteria within the occupational form. For example, the culture provides normative criteria for appropriate dressing, and a therapist can use a standardized test to assess whether a patient's performance and impact (the clothing in relation to the body) match those norms. A characteristic of objective assessment is interrater reliability (two or more trained raters agree after independent observations). Subjective success, on the other hand, is defined as occupational performance and impact that match the person's own purposes. For example, a patient's subjective purpose might be satisfied by independently donning only some of the clothes typically worn in our society, or a patient's purpose in dressing might exceed usual sociocultural criteria, or a person's purpose might involve a unique dressing goal, such as the donning of a personally meaningful brooch or decorative belt, or a patient's purpose might simply be to match the usual sociocultural criteria for dressing.

In CFTO, purpose is an internal process that arises from the unique and personally experienced meanings that the person assigns to the occupational form. Purpose is not directly observable by the therapist or others; the only access to purpose (and hence the only access to the evaluation of subjective success) is by listening to what the person says and by observing what the person does over time.

Several formal methods have been developed recently to measure patient-identified goals and satisfaction with occupational performance. The Satisfaction with Performance Scaled Questionnaire (Yerxa & Baum, 1986) is a quantitative scale of satisfaction with performance in daily occupations and community living. The Self Assessment of Occupational Functioning (Baron & Curtin, 1990) promotes collaborative treatment planning between the patient and occupational therapist, as called for in the Model of Human Occupation (Kiellhofner, 1995). Baron, Kiellhofner, Goldhammer, and Wolenksi (1999) developed the Occupational Self Assessment (OSA) from a Rasch-based measurement perspective. These instruments elicit written responses to predetermined items, but Goal Attainment Scaling (GAS; Ottenbacher & Cusick; 1993) involves an interview process that can be used in conjunction with the open-ended identification of self-identified goals (Trombly, Radomski, & Davis, 1998). Use of the GAS requires a high level of skill on the part of the therapist to quantify various levels of goal achievement. The Canadian Occupational Performance Measure (COPM) involves a formal interview that elicits open-ended, patient-identified goals and patient-rated quantitative ratings of those goals (Law et al., 1990; Law, Baptiste, et al., 1994). The COPM is “an outcome measure for use by occupational therapists to assess client outcome in the areas of self care, productivity, and leisure” (Law et al., 1990, p. 83), with a primary purpose of evaluating individual patient outcome by comparing self-ratings at the initial assessment with self-ratings at reassessment.

Some research evidence suggests that therapists have been slow to adopt these new methods for routine clinical practice in the United States. Neistadt (1995) reported on a survey of the methods used to assess patients’ goals for treatment in adult physical disability settings. She found that most therapists were using informal interviews and that the goals obtained from these interviews often were vague, without identifying specific, meaningful occupa-

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tions patients wished to do. Neistadt stated:

The use of formal procedures for assessing clients' goals compared to the formal procedures for assessing range of motion or muscle strength implies that collaborative goal setting is not as important to occupational therapists in physical dysfunction settings as the identification of clients' component skill deficits. (p. 434)

Nelson and Glass (1999) surveyed a random sample of occupational therapists working in SNFs, and no respondents reported the use of a formally structured or standardized method for assessing patient-identified goals in self-care.

Given the importance of patient-identified occupational goals and subjective success in occupation, we explored the use of the COPM in routine practice within a 90-bed subacute rehabilitation center. Occupational therapists and rehabilitation administrators reported that the COPM took too much time to administer within the constraints of the regulatory framework governing subacute and long-term care. Federal Medicare regulations state, “The time it takes to perform the formal initial evaluation and develop the treatment goals and the plan of treatment may not be counted as minutes of therapy received by the beneficiary” (Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update, Final Rule and Notice, 1999, p. 41661). “Minutes of therapy” lead directly to reimbursement categorization; therefore, lengthy evaluations are nonreimbursed costs to providers. In addition, some therapists reported that many patients newly admitted to subacute care were too frail to engage in a lengthy interview.

In a study of the COPM across settings and testers (N = 256), administration time ranged from 10 min to 180 min, with a median of 30 min (Law, Polatajko, et al., 1994). More recently, McColl, Paterson, Davies, Doubt, and Law (2000) reported that the COPM took an average of 46 min in a sample of 61 community-dwelling persons with disabilities. In a recent study to be submitted for publication, Johnson and Nelson (2001) studied the COPM, the SIGA, and another instrument. The three instruments were administered in a counterbalanced order to 30 female patients (mean age = 74 years, SD = 9.9) with various conditions in a subacute rehabilitation facility. They found that the SIGA took a mean of 5.6 min (SD = 2.8, median = 5) to complete, whereas the COPM took a mean of 18.8 min (SD = 4.7, median = 17.5). Durations are underestimates for both instruments because administration followed preparatory questions about prior functioning, home situation, and interests. A practical reason for the development of the SIGA as opposed to use of the COPM within the context of therapists hard pressed for time is the saving of approximately 13 min in the initial evaluation.

E. C. Nelson and Berwick (1989) argued that measurement tools are more likely to gain widespread use if they are brief, quick to comprehend, easy to score, and straightforward to interpret. Development of the SIGA has depended on the groundbreaking work of the COPM and has extended the ideas of person-identified goals and self-ratings of progress to the particular constraints of subacute rehabilitation in the United States.

The purpose of the study reported here is to evaluate the SIGA in terms of one aspect of construct validity. According to the American Educational Research Association, American Psychological Association, and National Council on Measurement in Education (AERA, APA, NCME, 1985), “Questioning test takers about their performance strategies or responses to particular items or asking raters about their reasons for their ratings can yield hypotheses that enrich the definition of a construct” (p. 10). An example of this method of assessing construct validity was reported in the Structured Observational Test of Function (Laver & Powell, 1995). Haynes, Richard, and Kubany (1995) argued that obtaining suggestions from the target population of an assessment often is an overlooked, but highly relevant method of validation. This argument is particularly true for assessments such as the SIGA and the COPM where the patients’ perceptions are paramount. McColl et al. (2000) recently reported the results of a study in which 61 community-dwelling persons with disabilities were asked a series of fixed-alternative and open-ended questions about their recent experiences with the COPM. All participants reported understanding the questions posed within the COPM, and most (n = 43) said that they had no problem in assigning quantitative ratings. Forty-five found the interview format of the COPM helpful in identifying their problems and telling the therapist about them.

The study reported here involves a series of fixed-alternative and open-ended questions about participants’ recent experiences with self-identified goals. Building on a prior study (reported in the Method section) conducted at the site for the development of the SIGA, the current study involves patients and occupational therapy practitioners at a different site—a hospital-based subacute facility. The guiding research question was: Do patients find the SIGA a useful way to identify and quantify goals with their occupational therapists?

Method

The overall study design involved a four-step process: (a) postadmission administration of the SIGA, (b) a structured interview inquiring about the usefulness of the postadmis-
sion SIGA, (c) predischARGE administration of the SIGA, and (d) a structured interview inquiring about the usefulness of the predischARGE SIGA. The SIGA was administered by the patients’ regular occupational therapy practitioner, and the structured interviews were administered by a graduate student of occupational therapy. The interviews consisted of fixed-alternative and open-ended questions. Fixed-alternative questions were analyzed as simple dichotomies, and open-ended questions were analyzed through categorization into convergent and divergent themes across participants.

Participants

Inclusion criteria were (a) referral to occupational therapy on admission to subacute rehabilitation in a midwestern hospital-based, 20-bed transitional care unit; (b) informed consent (as approved by two Institutional Review Boards); (c) participant ability to answer the questions posed on the SIGA; and (d) availability for a follow-up interview within 48 hr of completing the SIGA. Nineteen patients were unable or unwilling to give informed consent or to answer the SIGA questions at the admission assessment. Of the 30 patients successfully completing the SIGA admission step, 29 completed the discharge assessment (1 participant declined because of fatigue). The mean age of participants (20 women, 10 men) was 73.4 years (SD = 12.2). Primary diagnoses varied widely and included osteoarthritic conditions with joint replacements, fractures, cardiovascular conditions, pulmonary conditions, neoplasms, and gastrointestinal conditions. Most participants had additional conditions, such as hypertension, asthma, glaucoma, contusions, diabetes mellitus, nutritional disorder, and depressive disorder.

Instrument

The protocol of the SIGA is available on the World Wide Web (Melville & Nelson, 2001). After asking about prior functioning, home situation, and interests, the therapist asks the patient to identify tasks “you would like to work on or improve on in therapy before you go back home.” The therapist then uses interviewing skills to elicit one to four goals, as possible. If the patient has difficulty identifying specific goals, the therapist inquires about prior routines and “things that seem difficult to you now.” If the patient identifies goals of improving strength, balance, or any other components ability, the therapist asks, “What will increased [ability] help you to do in everyday life?” If the participant reports a desire to walk, the therapist asks about the participant’s destinations and related tasks. Without judging the importance or practicality of the patient’s goals, the therapist communicates a desire to record whatever the person wants to do or needs to do.

Next the therapist asks: “How well can you do all of the things you want to do on a scale from 0 to 10, with 0 being that you can’t do them at all and 10 being that you can do them your very best.” The therapist then shows the patient a form depicting the 0-to-10 scale in large print, with smiling and unsmiling faces as anchors to help patients interpret the meaning of the two ends of the scale. Further explanation is given as needed. If a patient reports a fraction (e.g., “2 1/2”) or more than one score per goal (e.g., “between a 2 or 3”), the therapist asks the patient to pick a single number. Optionally, then, depending on the patient’s wishes and level of fatigue, the therapist asks the patient to rate each identified goal on the same 0-to-10 scale. (This option was exercised in the current study.) At each follow-up measure (just before discharge in the current study), the therapist shows the patient a copy of the patient’s latest ratings and asks whether the patient wants to add new goals or to change goals. If changes are made, the patient gives an updated set of ratings according to the protocol described here.

Prior Study

The study reported here builds on a prior study of an earlier version of the SIGA. The earlier version did not involve a single rating of “all of the things you want to do” but involved a rating of each identified goal. In the prior study, the mean age of participants was 79.5 years (SD = 9.8), with 22 women and 8 men. Diagnoses varied widely. The SIGA was administered by the participant’s occupational therapist as part of the routine admission occupational therapy evaluation within 24 hr of admission. Within 48 hr, a graduate student of occupational therapy interviewed the participant to determine the participant’s perspective on the usefulness of the SIGA. At the beginning of the interview, the graduate student oriented the participant and presented a photocopy of the SIGA as completed by the therapist. The goals and scores were read aloud by the student. In all, 11 questions were designed to elicit fixed-alternative responses (yes vs. no vs. unsure), with the opportunity for recorded comments (Kerlinger, 1992, pp. 441–442). Three additional questions were designed to elicit open-ended responses. Construction of the interview protocol was influenced by a study of the use of the COPM (McCull et al., 2000).

The results generally supported the usefulness of the earlier version of the SIGA from the patients’ perspectives. Twenty-nine of 30 participants believed that the goals written on the assessment form were their actual goals for themselves. The only participant denying the validity of the goals made suggestions for modifying one of her two goals. Thirteen participants reported difficulty in rating performance on the quantitative scale. However, some of those
who reported difficulty nevertheless provided interpretable scores. In answer to the final open-ended item (“Should the therapist come up with goals for you, or should you make your own goals?”), 12 said that the patient should have that responsibility, and 13 volunteered that it should be a joint responsibility. Only 4 thought that the responsibility should rest solely with the therapist.

Because of the prior study, the SIGA was revised into its current format. Asking patients to give a single rating for “all of the things you want to do” reduced quantification for the frail patient. Rating of individual goals remains an option on the SIGA for less frail patients, and this procedure was used in the current study. To help patients understand the scale, the large-print form with anchors of smiling and unsmiling faces was developed.

Procedure

The study reported here was similar to the prior study except for (a) use of the current SIGA, (b) use of a hospital-based subacute unit where practitioners lacked experience in the SIGA, (c) administration and testing of the SIGA at both admission and discharge, (d) administration of the post-SIGA interview questions by a different graduate student of occupational therapy, and (e) clarifying modifications in some of the interview questions. Training of the SIGA administrators involved viewing an instructional videotape and engaging in 1 week of trial administration of the assessment during routine evaluation on the unit. The research design called for patterns of therapist involvement and testing procedures that were compatible with the routine occupational therapy practice on the unit. The SIGA was administered by the participant's regular occupational therapist as part of routine occupational therapy evaluation within 24 hr of admission, and each patient completed the SIGA once again as part of the routine discharge evaluation. One therapist administered the SIGA to 24 participants at admission and to 5 participants at discharge. A second therapist saw 4 participants for the admission SIGA and 1 at discharge. A third saw 2 at admission and none at discharge. Three certified occupational therapy assistants administered the SIGA at discharge to the remaining 24 participants (20, 3, and 1, respectively).

To elicit the patients’ input on the usefulness of the SIGA, the graduate student conducted all admission interviews within 48 hr of the occupational therapy admission evaluation and conducted all discharge interviews between the time of the occupational therapy discharge evaluation and the actual discharge. The practitioners who administered the SIGA were not involved in the interview because participants may have found it easier to provide critical feedback to someone other than the person who administered the assessment (Bennett & Ritchie, 1975). The admission interview consisted of 11 fixed-alternative questions, with the opportunity for comments, and three open-ended questions (see Table 1). The questions were similar to those asked in the prior study, with wording changes to increase understanding and with increased probing of the validity of the quantitative scale.

The discharge interview consisted of eight fixed-alternative questions and two open-ended questions (see Table 2). Six of the fixed-alternative questions were the same as on the admission interview, and the two new questions inquired about changes from admission to discharge. One of the open-ended questions was the same as in the admission interview, and one inquired about how therapists helped the person work on identified goals.

Table 1. Participant Interview Responses to Fixed-Alternative Questions Posed Within 48 Hours of SIGA Admission Evaluation

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you remember making these goals? [The goals were presented.]</td>
<td>29</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Did you have enough time to decide what goals you wanted to work on?</td>
<td>26</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Did your therapist help you identify your goals?</td>
<td>17</td>
<td>13</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Are these your own goals, as opposed to what other people want for you?</td>
<td>29</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Right now, would you like to modify them?</td>
<td>10</td>
<td>20</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Did you have difficulty rating your performance on the 0-to-10 scale? [The scale was presented.]</td>
<td>9</td>
<td>18</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>If yes, was rating your performance still possible?</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>21</td>
</tr>
<tr>
<td>Does the 0-to-10 scale make sense?</td>
<td>24</td>
<td>4</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Is this score accurate? Does it indicate your best estimate of ability at the time?</td>
<td>27</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Right now, would you like to change the score?</td>
<td>7</td>
<td>22</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Do you think [the goal-setting process] helped your therapist realize what is important to you?</td>
<td>28</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. SIGA = Self-Identified Goal Assessment.

*Participants did not remember the scale. Not applicable. Participants could not see the scale well but reported verbally that it made sense. Participant concluded interview because of fatigue.
Results

SIGA

A total of 83 goals were identified at the admission evaluation by the 30 participants. As in the prior study, basic self-care goals were common, including transfers (11), bathing (9), walking to a particular place (5), toileting (4), dressing (4), standing to engage in a specific occupation (2), and shaving (2). Instrumental occupations also were cited: housework (14), meal preparation (10), shopping (3), and driving (2). Leisure goals involved socializing (6) (e.g., telephoning friends, group outings), hobbies (3), and pet care (1). Productivity goals included return to paid employment (2) and baby-sitting (1). Most of the goals were specific and distinct in nature, including bicycle riding, Christmas shopping, knitting, and care for grandchildren. However, some goals lacked specificity or reflected underlying component abilities (e.g., walking in general, increased endurance).

Participants’ mean overall rating of how well they could do all the things they wanted to do was 2.6 (SD = 2.0) at admission, whereas the mean discharge score was 5.9 (SD = 1.9). The mean change from admission to discharge was 3.3 (SD = 2.6), t(29) = 7.1, p < .001. In the quantitative ratings of individual goals, 22 participants reported progress from admission to discharge, 6 conveyed mixed results (scores went up on at least one goal and down on at least one other goal), and 2 showed declines.

Patient Interviews

Table 1 summarizes participants’ responses to the fixed-alternative questions in the admission interviews and Table 2 summarizes those in the discharge interviews. Both at admission and at discharge, all but 1 participant remembered making the goals, and more than 90% of the participants confirmed that the listed goals were their “own goals as opposed to what other people want.” However, one third of the participants at admission were ready to modify their goals within 48 hr of making them. (All but 1 wished to add goals, such as returning to church and going to the mall.)

Eighteen of 30 participants reported no difficulty rating their performances on the quantitative scale at admission, and this proportion increased to 21 of 30 at discharge. At the admission interview, 5 of the 9 who reported difficulty with the scoring scheme nevertheless were able to provide scores, and at discharge, all 9 stated that a rating was possible. Twenty-four participants said that the quantitative scale “made sense,” but 2 had visual problems with it. Ninety percent of the participants at admission and 87% at discharge stated that the score was accurate and indicated their best estimate of ability. Some of those who indicated that the score was not accurate had changed their minds about their true abilities from the time of assessment to the time of the interview. Revised scores could reflect perceptions of increased capacity or fatigue (e.g., “I’d like to put it to a 3 today—I’ve had a hell of a day”).

At the discharge interview, 23 of 30 participants reported that their personal goals had not changed from admission to discharge, and 26 of 30 stated that their scores were good indicators of progress from admission to discharge. Of the 4 who said that their scores were not good indicators of change, some wanted to change the scores, but 1 who had an apparent gain from 2 to 5 questioned the usefulness of these numbers: “No, I don’t think so much [of the score]. My arm has not improved well. I always feel so weak.” Finally, 24 of 30 participants reported that their personal goals were addressed in therapy. Some of those who reported that their personal goals had not been addressed retained hope that their goals would still be addressed in the hours before discharge.

Answers to the three open-ended questions were categorized into convergent and divergent themes (Patton, 1990, pp. 402–404). The interviewer, another graduate student, and the research advisor categorized and recategorized the data until themes were mutually agreed on. Admission and discharge responses varied widely to the open-ended
question, “In general, how did you feel about identifying your goals for therapy?” Some participants stated that the goal-setting process enhanced their motivation for participation in therapy or helped them to focus in a positive way on recovery. For example, 1 participant said, “If you have something definite in mind, you’ll work harder.” Goal identification also was seen as a method for ongoing reevaluation (e.g., “then you know if you made any progress or not”). Some responses were general in nature (e.g., that goal identification was enjoyable or helpful), and a few indicated that the process was not helpful. For example, 1 participant reported that her personal goals were not addressed in the actual therapy she experienced in her stay on the unit.

For responses to the question of how participants came up with their goals, the following categories were derived: (a) occupations perceived as necessary for discharge, (b) occupations perceived as difficult or painful currently, (c) ideas elicited through therapist interaction and help, (d) occupations perceived as necessary for independence from the assistance of others, (e) occupations that are personally meaningful and important, and (f) undecided. For example, 1 participant said, “I want to get out of here. It’s more or less the things I need to do to get out of here.” Another said, “My grandchildren were here last night, and [the child] cried and cried because he couldn’t get up on my bed, and I couldn’t lift him. It breaks my heart.” Fifteen participants said that they should make up their own goals for therapy; 3 said that goal setting was the therapist’s responsibility; and 11 volunteered that it should be a joint effort. The answer to this question appeared to depend on two main beliefs: (a) Patients knew best about their own enduring personal characteristics, aspirations, and life circumstances, whereas (b) therapists had the training and experience to know about patterns of recovery in rehabilitation. Finally, in response to the question on how the therapist helped the participant work on self-identified goals, some answers reflected the therapist’s verbal reminding about the goals and other answers reflected therapeutic methods logically related to the goals (patient education, practice of goal occupations, or exercise related to goal occupations).

**Discussion**

The results demonstrate that the SIGA was effective in helping participants to identify personally meaningful goals. This finding mirrored the prior study. Despite some reported difficulty in quantifying performance, most participants were able to use the 0-to-10 scale and believed that their scores were both accurate and useful in the therapeutic process. Participants reported less difficulty with quantification at discharge than at admission. Open-ended responses confirmed that the quantitative scale could become part of a patient’s vocabulary in describing the process of recovery; for example, 1 participant stated that she wanted to “get back to doing some cooking because that’s a measure of my life. My goal is to get an 8.” Most patients believed that the SIGA process was helpful to the therapists, and some reported that it enhanced their own purposes in therapy.

Responses also indicated that the SIGA process encouraged participants to reflect on their recently changed and still changing personal capacities and how these capacities matched up with their past patterns of occupation, their anticipated patterns of occupation, and their ideal patterns of occupation. In future research, it would be interesting to conduct randomized clinical trials comparing patients who have experienced the SIGA or COPM process with those who have not received this type of assessment in terms of knowledge of personal capacity, beliefs about responsibility for the goal-setting process in therapy, perceptions of whether personal goals are addressed and achieved in therapy, and outcomes in the postdischarge environment.

Nelson and Glass (1999) found that occupational therapists working in nursing facilities and subacute rehabilitation focused on basic self-care much more than other functions identified in the federally mandated Resident Assessment Instrument (HCFA, 1995). The SIGA may be a way to expand the scope of occupational therapy practice in these settings, where current practice often is limited to self-care and the motoric abilities required for self-care. In the current study, participants identified unique goals that may not have been addressed in therapy if the SIGA had not been administered. This also was true in the prior study, where participants identified goals to take a bus to a local mall; to walk around the apartment; to set up a reception buffet; to get on a plane to visit a sister in California; to get down the basement steps to model trains; and to walk to the senior center for a meal, card game, and line dancing. Those looking forward to discharge from an extended period of hospitalization may find added meaning and purpose in unique and personally defined goals. Both the SIGA and the COPM (Law, Polatajko, et al., 1994) have elicited a wide range of personally meaningful goals in addition to self-care goals. As Radomski (1995) put it, “There is more to life than putting on your pants” (p. 487).

A few of the goals elicited by the SIGA in the current and prior studies were vague (e.g., standing or walking in unspecified situations) or focused on component abilities (e.g., endurance, pain, fatigue) despite the SIGA protocol calling for specific occupations. Even in these cases, the patient might be offering the therapist valuable information about knowledge of personal capacity and feelings about
In 1994, five of the same six authors stated: “While the initial numeric scores do not have inherent meaning by themselves, the interview process with the clients will certainly provide guidance on what areas should be addressed with the greatest priority” (p. 196).

These comments suggest recognition of a special problem in using the COPM in group aggregations. It is possible to argue that the numbers generated by the COPM lack logical continuity across participants. For example, if one person improves 5 points in dressing, and if another improves 3 points in playing the piano, what is the mathematical relationship between the 3 and the 5? There appears to be no logical way one can say that one value is greater than another. If this reasoning holds, the use of such numbers as representing a continuous ordinal-level or interval-level variable in outcome studies appears questionable. On the other hand, if one person rates self-performance as a 3 in dressing at initial assessment and as a 6 at discharge, and if another person rates playing the piano as a 1 at admission and as a 6 at discharge, it appears logical to argue that two persons have shown improvement in their self-identified goals. Perhaps then the use of such an instrument in across-subjects aggregations should be restricted to the nominal level of measurement (whether the person improves in specified self-identified goals or not).

The version of the SIGA used in the prior study had the same problem as the COPM in that ratings of different goals might not be comparable. However, the current version of the SIGA allows the possibility of aggregating responses across participants because the participant is asked to make a rating of how well he or she is able to do all the things he or she wants to do. Here each participant is asked to respond to the same question, whether at initial assessment or at reassessment. Still, it is premature to recommend the SIGA as an outcome measure. The SIGA overall rating and other single-item measures that cannot be tested for internal sources of variance must always be used with caution. Indeed, we believe that the future of the SIGA and the COPM in occupational therapy outcomes research will be not as outcomes measures (dependent variables) but as interventions reflecting essential principles of occupational therapy (randomly assigned conditions of an independent variable).

The prior study together with the current study confirm that the SIGA can be useful in subacute rehabilitation care within SNFs as well as within transitional care units of hospitals. However, it is clear that the SIGA is not appropriate for all patients in subacute rehabilitation. In the study reported here, we found that 19 of 49 potential participants were unwilling or unable to participate. A limitation of the

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opportunities provided by occupational therapy and rehabilitation from admission to discharge to the postdischarge environment, and perceptions of the site for occupation.

Validation of the COPM provides several models (Chan & Lee, 1997; Law, Polatajko, et al., 1994; McColl et al., 2000; Toomey, Nicholson, & Carswell, 1995; Wressle, Samuelson, & Henrikssoon, 1999) for needed future study of the SIGA: (a) test–retest reliability, (b) clinical use from therapists’ perspectives, (c) concurrent validity with instruments such as the COPM and OSA, (d) examination of the relationships between progress in individual goals and progress in the overall rating (this may be thought of as an aspect of construct validity), and (e) convergent and divergent validity with common outcomes measures in occupational therapy and rehabilitation. Interrater reliability of self-report measures is difficult to study, but interrater differences in interview styles and the effects of different interview styles on results could be investigated. In addition, predictive validity of occupation in the postdischarge environment should be studied. Finally, it is important to investigate the processes whereby the patient modifies personal goals, perceptions of personal capacities, perceptions of the postdischarge environment, and perceptions of the opportunities provided by occupational therapy and rehabilitation from admission to discharge to the postdischarge site for occupation.

Conclusion

The SIGA is a new instrument designed for use in the fast-paced climate of U. S. subacute rehabilitation and SNFs. The SIGA is an efficient way to structure a dialogue between patient and practitioner about the patient’s goals and personally defined levels of success.

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References


