Person-Centered, Goal-Oriented Care Helped My Patients Improve Their Quality of Life

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When the goal is to help patients improve their quality of life, it makes sense to focus directly on the activities and relationships that are most important to each patient. This can be accomplished most effectively by following a three-step process that includes 1) connecting with the patient around what matters to them, 2) co-creating a goal-oriented plan, and 3) collaborating with patient, family, team members, and consultants to increase the probability of success. Once this approach has been mastered and the necessary systems, processes, and relationships are in place, this should not take more time than a problem-oriented approach, and it will almost certainly be more satisfying for both physician and patient. The impact on population-based quality metrics is uncertain. Though fewer patients may choose to follow standard recommendations, those who do may be more likely to adhere to them. (J Am Board Fam Med 2024;37:506–511.)

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Introduction

Concerns about quality of life (QOL) are a common reason people seek medical care. Although QOL has many components,[1] most relevant to primary care is the ability to comfortably engage in personally enjoyable and meaningful activities and relationships. Although helping patients manage their medical problems can be helpful, focusing directly on the patients' QOL priorities can often be more effective. Primary care physicians can do that using a goal-oriented adaptation of the 3 Function Model of Cole and Bird,[2] developed as a roadmap for the medical interview, which includes: 1) *connecting* with patients by helping them clarify the activities and relationships most important to them; 2) *co-creating* a plan of care focused on those activities and relationships; and 3) *collaborating* with patients, their families, and other team members to maximize patients' chance of success (Table 1). We propose that this person-centered, goal-oriented approach, once mastered and supported by appropriate systems, processes, and teamwork, requires no more time than a problem-oriented approach, and is more effective and more rewarding for all involved. We have created the following fictional case to illustrate how it looks in practice.

Mabel

Mabel is a 71-year-old divorced woman recently discharged after a 2-month hospitalization for a SARS COV-2 infection. Her medical problems include obesity, hypertension, type 2 diabetes, and osteoarthritis in her knees. Her discharge medications include nasal oxygen, hydrochlorothiazide and lisinopril for hypertension, metformin for diabetes, and acetaminophen when needed for pain.

Connecting

Demonstrating genuine interest in a person's life and priorities helps create a therapeutic relationship. Questions that fit comfortably within most clinical encounters include:

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Table 1. Goal-Oriented Adaptation of the Three Function Model of Cole and Bird

Functions	Components	Office Systems
Connect	1) Clarify important activities and relationships 2) Explore underlying values 3) Identify obstacles, challenges, and opportunities	1) Train office staff in the goal-oriented approach 2) Provide patient information about goal-oriented care 3) Develop protocols that facilitate pre-visit information collection, access to outside records, medication, and family involvement when desired 4) Create electronic record templates to facilitate goal-oriented data collection and documentation
Co-Create	1) Share relevant information 2) Brainstorm strategic options 3) Negotiate an initial plan	1) Develop strong professional relationships with rehabilitation therapists, home health agencies, and community resources. 2) Create paper or computer order set templates that include goal-focused referrals to rehabilitation therapists, home health clinicians, durable medical equipment, and community resources 3) Develop a process that engages non-physician clinicians and office staff in care plan construction and communication. 4) Create a referral letter template that specifies patient goals
Collaborating	1) Establish an implementation support plan 2) Adjust the plan based upon new information	1) Create a care plan template that includes follow-up arrangements, contact information, and contingency plans that can be easily incorporated into visit summary and referral letters. 2) Develop a process that engages non-physician clinicians and office staff in care plan implementation and oversight. 3) Create a documentation process that makes it possible to track progress and adjust goal-oriented plans of care.

- How have your recent health challenges affected your daily life?
- What does a typical day look like for you now? (Walk me through a typical day in your life.) How is that different from before your illness/injury?
- What are the most significant challenges you face each day?
- What would you like to be able to do that you can't do now? What prevents you from doing those things?
- What activities and relationships are most important to you? Why are they important?
- What additional knowledge and skills do you need to have the kind of life you want?

Based on the answers to those questions, it is usually possible to agree on 1 or 2 goals that can serve as the basis for care planning. The goals need not be entirely realistic at this point because they can be adjusted over time. The most important requirement is that they be motivational. However, when a goal is completely unrealistic, it can be helpful to explore the values underlying the goal to see if there might be other ways to support those values. For example, if a person loves animals but is unable to own a pet, they might be able to volunteer at a pet therapy organization. A simple way to identify values is to ask, "Why is that activity or relationship important to you?" or "Why would it be important for you to be able to do that?"

In many cases, connecting (i.e., identifying key goals) is straightforward. In some real-life examples, Jeremy, a thirty-five year-old man reported to a colleague that his chronic rotator cuff injury was preventing him from hunting with a bow and arrow. Helen, a woman in her eighties was having difficulty putting on her shoes and socks because of arthritis. A 75-year-old man named Alfred with congestive heart failure explained that he did not like to take his diuretics because of limited access to a bathroom during morning senior center activities.[3]

Mabel (Continued)

Before the infection, Mabel lived independently and worked part-time as a grocery store cashier. She enjoyed walking her small dog and playing with her grandchildren. Of greatest concern to her now is that she is too tired and short of breath to do much of anything other than basic self-care – bathing, dressing, toileting, taking her medications, and eating preprepared foods. Since the hospitalization, her daughter and a neighbor have been helping her with shopping and some cleaning, but she wants to regain her independence, and she needs to work part-time to afford to remain in her home. She cherishes her relationships with her daughter and grandchildren and does not want to be a burden. Her goals are to be able to continue to attend to her basic needs and take care of her dog with as

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little help as possible and to eventually return to part-time work at the store. The values underlying those goals are personal autonomy and positive relationships.

Co-Creating a Plan

Once the preliminary goals have been clarified, the next step is to consider ways to achieve them. Because physician, patient, and family caregivers all have relevant information and expertise, and because patients tend to be more motivated when the ideas are their own, the best approach is for the involved parties to share information and brainstorm potential strategies before settling on a plan.

When a patient's goals involve mobility and day-to-day functioning, a physical therapy or occupational therapy referral or a prescription for adaptive equipment can be helpful. In a recent observational study of participants in the US National Health and Aging Trends Study, 42% of those over 65 had unmet needs for adaptive equipment to ameliorate problems with bathing and toileting alone.[4] In a recent report, the World Health Organization has suggested the need to bring more rehabilitative expertise (eg, physical and occupational therapists) into primary care, as some European countries have done.[5,6]

Cocreation can also be straightforward. For example, it occurred to Jeremy that, with a physician note, he might be able to use a crossbow for hunting. Helen was referred to an occupational therapist who taught her to use a sock donner and long-handled shoehorn. Alfred, the man with heart failure, was instructed to take his medications in the early afternoon.

Mabel (Continued)

Mabel is experiencing symptoms resulting from her infection and the adverse consequences of a prolonged hospitalization. Her physician explains that after severe SARS COV-2 infections, patients can have persistent symptoms for many weeks.[7] Regaining strength and endurance after a period of prolonged hospitalization can also take a long time.[8] It is important for her to understand that achieving her prior level of fitness will likely take months of rehabilitation and will require substantial physical and mental effort. Her physician frames her situation as a personal challenge and compares it to challenges she faced successfully in the past, while acknowledging some uncertainty about how much function she might regain. He makes sure to link rehabilitation strategies to her goals of not being a burden on her family and improving her day-to-day functioning.

Mabel offers some ideas about how to make personal care and housework less challenging (eg, using the downstairs bedroom and signing up with meals on wheels through her church). She raises concerns about transportation to health care appointments. When her physician mentions virtual medical visits, she says she has a smart phone and enjoys video calls with her granddaughter but has never tried to use her telephone or computer for a virtual doctor's visit.

Her physician discusses the availability of nurses, occupational therapists, physical therapists, social workers, and in-home aides through a home health agency. He also mentions that pulmonary rehabilitation has been shown to improve recovery from SARS COV-2-induced pulmonary symptoms.[9] She wants to start more slowly, and they agree to revisit that option once more urgently needed strategies are in place. Because keeping her blood glucose levels below the renal threshold can prevent osmotic diuresis, thereby reducing symptoms of dehydration, and because electrolyte abnormalities from her antihypertensives could reduce her strength and endurance, they agree on a blood chemistry panel and dipstick urinalysis.

Once all the options have been discussed, Mabel and her physician agree on the following course of action. She is referred to a local home health agency, with requests for nursing to make sure she is able to manage her medications and oxygen and to monitor her oxygenation for the next few weeks, an occupational therapist (OT) to help her decide how to more efficiently manage basic and instrumental activities of daily living and to teach her how to use her telephone or computer for telehealth appointments, and a social worker to help her arrange a meal delivery service and to support her efforts to negotiate agreements with her employer and mortgage lender. Clarification of Mabel's goals facilitates interdisciplinary teamwork.

Collaborating

As a plan is developed, it is important to construct the scaffolding needed to support its implementation.[10]

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That may include proactive follow-up phone calls and electronic-health record messages to the patient, visits between members of the primary care team and the patient and family, and communications with consultants and referral agencies involved. The purpose and periodicity of those interactions should be agreed upon, documented, and monitored along with any follow-up arrangements, tests, and procedures that need to be scheduled. In addition, it is important to provide patients with action plans that include when and how to contact the primary care team if things are not going as planned. Once the necessary system components are in place to create and document such plans, this need not be difficult or time consuming.

Very few plans unfold as expected. Every glitch provides valuable information for plan improvements. In fact, such adjustments should be expected and welcomed. Usually they are relatively minor, but sometimes they require revisiting the goal and its underlying values over a series of visits.

Mabel (Continued)

The OT helps Mabel rearrange her living areas and teaches her how to reduce the amount of energy required for essential tasks. Arrangements are made to have grab bars installed in her shower to reduce her fall risk. She obtains a rollator with a seat to use when walking her dog until her strength and endurance improve. She learns to use her smart phone for telehealth visits, and her daughter joins her on a scheduled telehealth follow-up visit with Mabel's physician.

At that visit, a plan for collaboration is developed that includes the frequency and locations of follow-up visits and lab tests, contact information for the primary care team member responsible for coordination, the expected nature and duration of home health services, and the kinds of unexpected events that should prompt a call for assistance.

Pulmonary rehabilitation is again discussed, and the OT agrees to help Mabel investigate it further. She discovers there is a several-month wait for a spot in the program, but she identifies a telehealth option that seems promising and helps Mabel enroll.[11]

Consideration of Other Health Goals

Improving QOL is only 1 of 4 types of health care goals. The others are prevention of premature death, optimizing personal growth and development, and ensuring a good death.[12] It can be helpful for both clarity and efficiency to focus on 1 goal type at a time, and, in particular, to separate discussions of prevention from discussions of current quality of life.[13] In Mabel's case, blood pressure control could be discussed at greater length during prevention visits.

Of course, QOL goals sometimes conflict with other goals. For example, long-term treatment with corticosteroids, opioids, or nonsteroidal anti-inflammatories may improve current quality of life while increasing the risk of premature death and future disability.[14,15] Antipsychotics may reduce symptoms of depression but increase the risk of premature death in some older patients.[16] Treatments may be beneficial but too burdensome to be worth the effort. These trade-offs become clearer within a goal-oriented approach, and they should be discussed during plan development.

Diagnosis and Treatment of Medical Problems

Within a person-centered, goal-oriented approach, diagnosis and treatment of medical problems are almost always a consideration after clarification of patients' goals and priorities. Rather than being the focus of attention, however, they are viewed as obstacles to goal achievement, challenges, and opportunities for personal growth and development. Diagnosis and treatment are interventions worth considering when they are relevant to goal achievement and feasible and acceptable to the patient and their families.[17]

Effectiveness

It is logical to assume that QOL goals are more likely to be achieved when they are the direct focus of care rather than an indirect consequence of removing obstacles (eg, treatment of disease). And there is now reasonably good evidence to support that assumption from research in the fields of geriatrics, palliative care, and occupational therapy.[18–22] Even in rehabilitation settings, where recovery from acute medical conditions like stroke and spinal cord injury are largely determinative of future QOL, evidence suggests that there are greater improvements in quality of life and self-efficacy with a goal-oriented approach.[23]

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In addition, person-centered, goal-oriented care comfortably incorporates functional, emotional, and social needs and priorities, and it broadens the range of potential strategies, resulting in more robust care plans. It also facilitates shared decision making and interdisciplinary teamwork.[24] Importantly, the 3-function approach we have described supports patients' psychological needs for connection, autonomy, and competence, thereby enhancing motivation.[25]

Time Requirements

We are sensitive to the time and income pressures on primary care clinicians and understand that what we are proposing is both idealistic and challenging. However, based on our own experience and that of others, the approach we are suggesting, once mastered, need not take longer than a problem-oriented approach once the required processes and systems are in place.[26] The fictional case we created is more complicated than most, but the initial posthospitalization visit with Mabel could probably be completed in 30 minutes assuming the discharge summary is available. Follow-up visits could be accomplished in approximately 20 minutes. Including interdisciplinary team members within the primary care practice, such as nurse care managers, rehabilitation therapists, social workers, and mental health professionals can save physician time and improve care quality. Documentation and implementation of the collaboration plan can be facilitated using computer templates, checklists, and order sets. Separating QOL visits from preventive care visits can also improve efficiency.[13]

Quality Metrics

When the focus is on goal-achievement rather than diagnosis and treatment of medical problems, population-based quality metrics do not always apply. In Mabel's case, it may only be necessary to keep her blood glucose levels below renal threshold to achieve her QOL goals. Given her age and life expectancy, tighter control is likely to provide her little benefit and could result in harm.[27] Though fewer patients may choose to follow standard recommendations, those who do may be more likely to adhere to them. The National Committee for Quality Assurance (NCQA) is currently developing new individualizable metrics that may encourage a goal-oriented approach.[28] The Age-Friendly Health Systems movement, focused on "what matters most," promoted by the Institute for Health Improvement, may also increase the visibility of a goal-oriented approach to patient care and result in more appropriate metrics.[29]

Conclusions

A major purpose of health care is to help people enjoy the highest possible QOL. Beyond relief of symptoms, primary care physicians can often be most helpful when they understand patients' goals and priorities and are able to co-create plans of care and provide the implementation support needed to ensure success. To be able to use this approach effectively, physicians may need some training and assistance implementing the 3 function model and practices will need to develop the process components required to maximize effectiveness and efficiency.

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