

## Qualitative Research

# What does it take to set goals for self-management in primary care? A qualitative study

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## Abstract

**Background.** There is an increasing number of patients with a chronic illness demanding primary care services. This demands for effective self-management support, including collaborative goal setting. Despite the fact that primary care professionals seem to have difficulties implementing goal setting, little information is available about the factors influencing the complexity of this process in primary care.

**Objective.** The aim of this study was to contribute to an understanding of the complexity of self-management goal setting in primary care by exploring experts' and primary care professionals' experiences with self-management goal setting and viewpoints regarding influencing factors.

**Methods.** A descriptive qualitative research methodology was adopted. Two focus groups and three individual interviews were conducted (total participants  $n = 17$ ). Thematic content analysis was used to analyse the data.

**Results.** The findings were categorized into four main themes with subordinated subthemes. The themes focus around the complexity of setting non-medical goals and around professionals' skills and attitudes to negotiate and decide about goals with patients. Furthermore, patients' skills and attitudes for goal setting and the integration of goal setting in the time available were formulated as themes.

**Conclusions.** Setting self-management goals in primary care, especially in family medicine, might require a shift from a medical perspective to a biopsychosocial perspective, with an increasing role set aside for the professional to coach the patient in expressing his self-management goals and to take responsibility for these goals.

**Key words:** Chronic disease, goals, patient-centred care, primary health care, qualitative research, self-care.

## Introduction

Internationally, the impact of the rapid increase of people living with chronic conditions is a concern for the health care sector (1). This impact leads to a growing interest in effective self-management

support for patients within primary care (2). Self-management support is defined as the actions that health care professionals perform, tailored to each patient's needs and capabilities, aiming at assisting and encouraging patients to become good managers of their conditions (3).

Self-management support programmes incorporate goal setting as an important feature as it is thought to enhance patient autonomy (3). In primary care, the term ‘collaborative goal setting’ is frequently used, described as a circular process, including discussing, setting, planning and evaluating goals between a patient and a health care professional (4).

Most of the goal-setting literature originates from the field of rehabilitation (5,6). Patient-centred goal setting has been described as an essential element of any successful rehabilitation programme (5). Yet, the implementation of goal setting in rehabilitation is complex and professionals often hesitate to actively involve patients. In a systematic review, Rosewilliam *et al.* (6) described professionals’ lack of skills and lack of time for goal setting as factors influencing the complexity of goal setting in rehabilitation. Moreover, patients themselves sometimes do not want to be actively involved (6).

Until now, only few studies examined experiences of goal setting in primary care. These studies found that professionals seem to have difficulties using goal setting in routine care as they perceive it as time-consuming and complex (7,8). Little information is available regarding factors influencing the complexity of the goal-setting process in primary chronic care. This study contributes to an understanding of the complexity of self-management goal setting in primary care by exploring experts’ and primary care professionals’ experiences with self-management goal setting and viewpoints about influencing factors.

## Methods

We adopted a descriptive qualitative research methodology (9). Two focus groups [one focus group with professionals ( $n = 6$ ) and one focus group with experts ( $n = 8$ )] were organized to realize an interactive discussion (10). Additionally, we conducted three semi-structured individual interviews ( $n = 3$ ) with professionals who were not able to attend the focus groups in order to ensure representation of all relevant primary care disciplines. The same questions were asked both in the focus groups and in the interviews.

To capture different perspectives, we purposefully sampled primary care professionals and experts from different disciplines

through our network. Out of the 20 professionals and experts we invited, 17 agreed to participate. We invited primary care professionals working in different practices of family medicine, occupational therapy, physical therapy, psychology and social work, as these disciplines often see chronically ill patients. They had to (i) work with chronically ill patients within primary care in the Netherlands and (ii) use collaborative goal setting. Recruited experts had expertise in different fields, closely connected to self-management goal setting: patient representation, self-management (support), patient–professional communication, patient-centred practice, shared decision making, evidence-based practice and informal care giving. In total, eight experts and nine primary care professionals participated in the study. Information about data collection and characteristics of the participants can be found in Table 1.

All interviews were conducted between April and June 2013. To facilitate the focus groups, an experienced external discussion leader, who is a qualitative researcher on self-management, but not part of the research team, chaired the meetings. The individual interviews were conducted by the first author. Open-ended questions were asked regarding the interviewees’ experiences with goal setting, viewpoints about relevant factors and perceived barriers and facilitators. The main questions, which were asked, can be found in Box 1. The focus groups and interviews were audio-recorded and transcribed verbatim.

After finishing data collection, the data were analysed using principles of content analysis (11). Nvivo 9.0 was used to support coding (12). A two-stage analysis was applied by two researchers (SAL, JJJvD) who each read all the transcripts independently and repeatedly. Next, they coded all the data and compared their open codes until consensus was reached. This was followed by axial coding, whereby codes were grouped into categories (11).

During the process, several strategies were used to ensure the trustworthiness of the study. Firstly, by inviting an external discussion leader, the researchers’ influence on the data collection in the focus groups was reduced (13). Secondly, independent coding by two researchers diminished subjectivity (13). Thirdly, an analysis diary was kept in order to account for, and acknowledge, the involvement

**Table 1.** Data collection and study sample

Profession	Expertise	Gender	Age (years)
Focus group with experts (April 2013, length: 90 min, 8 participants)			
Project leader health care organization	Self-management	Female	53
Researcher, teacher	Patient–professional communication	Female	66
Manager patient organization	Informal care giving	Male	69
Researcher, teacher	Patient-centred care	Female	56
Teacher	Evidence-based practice	Male	58
Researcher	Patient–professional communication	Female	50
Researcher, teacher	Shared decision making	Female	50
Researcher, manager health care organization	Patient–professional communication	Female	55
Focus group with professionals (May 2013, length: 90 min, 6 participants)			
Practice nurse	Geriatrics, chronic diseases	Female	49
Social worker	Youth care	Male	56
Physical therapist, teacher	Geriatrics, chronic diseases	Male	49
Practice nurse	Geriatrics	Female	49
Physical therapist, teacher	Psychosomatic, geriatrics	Male	52
Occupational therapist	Geriatrics, psychology	Female	58
Individual interviews with professionals (June 2013, length: 60 min each)			
Family physician, teacher	Family medicine	Male	48
Practice nurse	Psychology	Male	42
Psychologist, researcher	Neurology	Female	38

### Box 1. Main questions asked in focus groups and individual interviews

1. What is the first thing that comes into your mind when you think about self-management goal setting in primary care?
2. What are your experiences with self-management goal setting in primary care?
3. According to you, what are relevant factors that influence the process of self-management goal setting in primary care?
4. What do you experience as barriers/facilitators to the process of self-management goal setting in primary care?
5. Did you miss a relevant question/factor in this discussion?

of the researchers' own perspectives (13). Fourthly, member checking was done. Participants were provided with the themes identified through analysis in written form to ensure that the researchers had accurately translated the participants' experiences into data, this to enhance the credibility of the study (13). All participants approved the themes.

## Results

The findings were categorized into four main themes with subordinated subthemes. Overall, participants talked mostly about their viewpoints on self-management goal setting. Detailed stories about their own personal experiences were less shared. Furthermore, despite the differences in background and expertise, professionals and experts reported similar viewpoints. Therefore, in the following section, we will not discriminate between the groups, but refer to them as participants, except where applicable. Moreover, the individual interviews did not reveal any new themes.

### Theme 1: setting non-medical goals

During the interviews, participants agreed with each other that there are differences in types of goals. Although medical self-management goals were considered to be important, they argued that patients' goals are often related to other aspects of everyday life. According to the participants, supporting self-management incorporates emotional issues, patients' daily activities and social participation. Therefore, setting goals on meaningful activities and participation was thought to facilitate motivation.

What makes a person's life worth living is different for everybody, and therefore people have different sub-goals about different aspects in their lives (practice nurse).

Moreover, setting different types of goals with patients was experienced as uncommon and difficult for many professionals. However, it was recognized that patients mainly want to set non-medical goals.

We were convinced that people would set goals like: I want to reduce my blood pressure. But no, of course not! People want to be able to go to the swimming pool again or to visit their daughter by bike (expert shared decision making).

### Theme 2: professionals' attitudes and skills

#### Being interested in the person

Participants found that being interested in the patient as a person was seen as a condition for setting patient-centred goals.

The most important thing for me is being interested in the person sitting in front of me. Ask 'Who are you?' instead of 'Which problems do you have?' (expert evidence-based practice).

#### Sharing responsibility with patients

According to our participants, a positive attitude towards patient-centred care also involves inviting and stimulating patients to take or to share responsibility for setting goals.

For me, it is always important to find a way to set goals together with an individual patient, to share responsibility and to create equality (nurse practitioner).

Our participants reported the importance of withholding professional expertise when aiming for sharing responsibility with patients. Starting a consultation with the professional's ideas and expertise can restrict self-management goal setting.

As a professional, I have many ideas about what a patient should do—he needs to get out and about, he has to get a new hobby—these are MY goals. But if I do not first explore the patient's needs, I will not establish trust and I will never be able to communicate my perspective without losing his attention and commitment (nurse practitioner).

The complexity of balancing between stimulating the patient to take responsibility and expressing one's expertise was brought forward by many participants. For most professionals, it was a challenge to come to a decision together with their patients.

This can also be a difficulty. How can I let a patient direct the process, whilst at the same time still try to reach the objectives that I find important? (physical therapist).

Experts were of the opinion that involving patients in decision making regarding their goals demands 'courage'. According to them, professionals may be concerned about losing control over the process, resulting in patients making the 'wrong' decisions.

It is all about the courage to make the patient's specific needs the focal point of the consultation and not one's own experiences and expertise (expert patient-professional communication).

#### Using understandable terminology

As regards professional skills, many participants saw the importance of using understandable language when formulating goals. Professionals' terminology might sometimes lead to feelings of intimidation among patients. Consequently, patients might not be open about their needs and goals. Professionals and experts in our study experienced difficulties avoiding professional terminology in goal setting.

It is difficult for professionals to formulate goals in the language of the patient. Goals are often too abstract and not tangible for the patient (expert patient-professional communication).

Just using the word 'goal', without explaining its meaning, could be too abstract for some patients.

We had a questionnaire asking people about their treatment goals. People often did not know what to answer. They often asked: What do you mean by 'Goals for treatment'? (expert self-management).

### Theme 3: patients' attitudes and skills

#### Being ready to participate

Patients' readiness for participation in goal setting was reported as one of the most influencing factors. Mostly, a lack of patients'

readiness for collaborative goal setting, frequently observed among patients recently diagnosed with a chronic condition, was considered to be one of the main barriers.

These patients [patients who had been recently diagnosed with a chronic disease] lost perspective, thinking that they could not achieve anything anymore. This is why they act very passively and wait for the professional to do something (expert self-management).

#### Having experience with goal setting

A lack of patients' experience in setting self-management goals was discussed as a barrier. Participants perceived that most people do not set or reflect on goals in everyday life. Expectations, therefore, should not be too high when patients have hardly ever set goals for their self-management with a professional before, let alone having any conception of what goals there might be.

People are obviously not used to setting goals themselves. The concept 'goal' is unclear for many people. They do not set goals in their everyday life (family physician).

In my research, the practice nurse was thought to set goals with the patient. But many patients did not understand and just did not react accordingly. They did not know what to expect [with regard to goal setting] (expert self-management).

### Theme 4: time and goal setting

#### Goal setting takes time

In all interviews, time was considered as one of the most significant barriers; goal setting takes time. Yet, in practice, the time available for setting goals is limited. A 10 to 20 minute appointment is too short, especially when patients are invited to reflect on goals for the first time. The lack of time is considered to be one of the reasons professionals skip goal setting and immediately address possible solutions for problems that they themselves have put on the agenda.

As a family physician I have 10 minutes for an appointment. And yes, sometimes it is like: Listen, we have to come to a decision. Let's think about solutions (family physician).

#### Patients need time

Participants further accounted that patients need time to clarify and reflect on their goals themselves.

I noticed that patients need time to reflect on issues that really matter to them. Could be that somebody returns a week later and says: I have thought about what we talked about, maybe it is a little bit different to what I talked to you about (expert patient-professional communication).

Several experts spoke of possible ways by which patients could be supported in gaining insight into their goals, saving time during a consultation. They reported that tools stimulating patients to think about their goals before and during the goal-setting appointment could facilitate patient participation and could be time efficient.

Talking about self-management, if we offer patients simple tools, which they can use independently and which stimulate thinking about they consider to be important, that would help them during the goal setting consultation (expert patient-centred practice).

### Discussion

In the light of contributing to an understanding of the complexity of self-management goal setting in primary care, we explored the

experiences and viewpoints of experts and primary care professionals. Four main themes emerged: (i) Setting non-medical goals, (ii) Professionals' attitudes and skills, (iii) Patients' attitudes and skills and (iv) Time and goal setting. Within these themes, barriers to self-management goal setting were most reported.

#### Setting non-medical goals

The complexity of setting non-medical goals was highlighted in our study. In the literature, three types of self-management can be distinguished: medical, social and emotional self-management (14). Likewise, it seems logical to set goals according to these types. However, making the link between medical goals and patients' social and emotional goals and explaining how these may be interrelated, thus applying a more biopsychosocial approach, seems to be a challenge for professionals (15). Literature suggests that the professionals' sense of responsibility to care for medical aspects may lead to a reluctance to initiate open self-management discussions with patients (7). In the Netherlands, as well as in the UK, family physicians increasingly work together with practice nurses (16,17). Practice nurses see chronically ill patients on a regular basis and therefore play a crucial role in supporting patients' self-management and setting personal goals (18). Yet, practice nurses are often educated to work according to protocols, focusing on medical management and disease-specific medical outcome indicators (16). Disease-specific medical outcome indicators, however, induce the risk of a fragmented, rather than an holistic, approach (17). Setting self-management goals may require rethinking primary care outcome indicators; a paradigm shift from primarily biomedical outcome indicators to patients' goal-oriented outcome indicators may be needed (19).

#### Professionals' skills and attitude

In our study, professionals' skills and attitudes to sharing responsibility for and deciding about goals with the patients were also found to be barriers. Literature suggests that professionals struggle with shared goal setting because they assume that their patients are not able to make decisions (6,20). In the Netherlands, awareness of the need of shared goal setting about patients' quality of life and self-management in chronic care is growing (21). It is suggested that for chronically ill patients it is necessary to first set personal goals in order to be able to make clinical decisions together (21). In family practice, the term 'patient-centred medicine' is frequently used. This concept incorporates teamwork between the professional and the patient and active engagement of the patient in the whole process of decision making (22). Taking this perspective, in certain situations, professionals will become coaches. This changing role requires professionals to continuously explore what really matters to the patient (23). To change primary care professionals' perception of their roles, comprehensive educational interventions focusing on professionals' skills and attitudes might be necessary and might need to become embedded in family professionals' education.

#### Patients' readiness to set goals

Our participants further discussed the importance of patients' readiness to set goals. Patients just diagnosed with a chronic disease often have difficulties in clarifying their own needs (24). Yet, in the course of time, by undergoing an adaption process and through professional support, a patient gains more insight into the disease, increasingly accepts the disease and copes more effectively (24). This fits the definition of goal setting, in which goal setting is seen as an iterative

process, instead of just one moment in time, allowing patients to continuously reflect on their goals (5).

Furthermore, patients' lack of experience with goal setting was also discussed in our study. Literature shows that patients do not expect their family physician or practice nurse to engage with them in discussions about non-medical goals (25). It is suggested that these expectations evolved from the biomedical focus of consultations that patients are used to undergoing (26). Applying a more biopsychosocial approach and changing the professional's role might probably support patients in expressing their self-management goals and to take more responsibility in achieving them (18). Still, it might be important to consider that not all patients are equally capable of setting goals or reflecting on their situation. Some patients are not able or willing to participate in self-management goal setting; others may need more support. In psychology literature, some techniques can be found, which support patients in reflecting on their goals, such as 'mental contrasting' (technique to imagine benefits and barriers for goal achievement) or 'forming implementation intentions' (technique to form if-then plans and specifying when, where and how) (27). It might be valuable to explore the feasibility and effectiveness of these kinds of techniques in primary care self-management support.

### Time

Time was considered as one of the most significant barriers to self-management goal setting by our participants. Participants reported that they have limited time and that involving patients in goal setting often takes too much time. Parry (28) suggests that professionals avoid patient participation in goal setting in order to spend more time on treatment. Again, the experience of time pressure could be due to the biomedical focus, the financial reimbursement professionals receive for reaching biomedical targets and professionals' conviction that goals need to be clear within a single consultation (18). The primary health care system might need to recognize that shared goal setting is a precondition for effective treatment of patients with chronic conditions. Acknowledging chronic care as long-term care, thus investing time in self-management goal setting within several consultations and delivering tailored support, could save time in the long run.

The barriers we found are comparable to barriers described in the rehabilitation context, although rehabilitation professionals often have more time per patient, regularly work together in inter-professional teams and focus on patients' functional outcomes from a biopsychosocial perspective (29). This shows the complexity of goal setting in practice and underlines its complexity in the primary care setting. Primary care may consider rehabilitation goal-setting practices aimed at overcoming barriers in goal setting, like the use of goal-setting instruments (e.g. Goal Attainment Scaling or the Canadian Occupational Performance Measure) to be patient-centred and time saving (6).

### Strengths and limitations

The quality of our study was enhanced by the use of strategies that ensured the trustworthiness, such as independent coding and a member check. Moreover, we reached data saturation, as the individual interviews did not generate new themes and we ensured the inclusion of several perspectives on self-management goal setting (13). Yet, it was striking that there was a high level of agreement regarding factors. Furthermore, participants in our study mostly expressed their viewpoints about barriers and challenges and spoke less about the detailed experiences on which they based their viewpoints. As regards the design, we chose focus groups acknowledged as being ideal to explore viewpoints (10). Yet, the choice for focus groups

may have induced conformity between the participants in our study. In addition, the main questions in the interview guide about factors and viewpoints might have stimulated a more cognitive approach to the topic. Asking participants to share stories and examples about their everyday work might have stimulated them to share more personal experiences. In addition, professionals had a special interest and might therefore also have approached the topic from an expert perspective. It may also be possible that, although professionals value self-management goal setting highly, personal experiences were still limited, as it is not yet common practice in primary care. Furthermore, although we included several different perspective and found common viewpoints, it is questionable whether our findings are generalizable, as our sample size was small (30). Finally, patients' personal experiences have not been taken into account in this study. Therefore, as a next step, exploration of patients' experiences with self-management goal setting and observations of consultations to get an insight into current work methods are required.

### Conclusion

In conclusion, we found factors influencing self-management goal setting in primary care, focusing around the complexity of setting non-medical goals, negotiating over and deciding about goals with patients, tailoring support to the individual patient and integrating goal setting in the available time.

We think that setting self-management goals in primary care, especially in family medicine, might require a shift from a medical perspective to a broader biopsychosocial perspective. Consequently, professionals might increasingly need to function as coaches, enabling patients to express their goals and to take responsibility in achieving them. This change does require a different set of skills and a different perspective on the distribution of available time.

### Declaration

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Ethical approval: the medical ethics committee of the Atrium Medical Center, Heerlen, the Netherlands. Participants' anonymity was ensured by the use of pseudonyms. Written informed consent to participate was obtained prior to gathering data.

Conflict of interest: none.

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