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Invited Commentary | Geriatrics

Making Care Fit in the Lives and Loves of Patients With Chronic Conditions

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Designing care plans requires patients and clinicians to work together to uncover the situation of the patient and to determine how to best respond to it.¹ For these care plans to fit individual patients and their lives, they need to be biomedically correct; consistent with patients' personal values, desires, goals, and context; and feasible to be implemented in daily life.² Patients with care plans that do not fit "receive tests and treatments they do not need, understand or implement, a result that is wasteful and harmful."^{2(p18)} In this issue of *JAMA Network Open*, Tinetti and colleagues³ describe common outcome goals and health care preferences of older adults with multiple chronic conditions, as elicited by an advanced practice nurse or case manager. The authors found that the goals of older adults were both realistic and actionable, and in previous research of their Patient Priorities Care (PPC) program,⁴ clinicians and other stakeholders believed that these goals can help clinicians in making decisions about the patients' care. A clinical trial found that eliciting patient priorities and providing this information to clinicians was associated with a reduction in treatment burden and an increase in discontinuation of medication use and in goal-aligned care.⁵ These findings yet again stress the importance of patients and clinicians working together and combining their expertise to make care fit.

The patient-clinician collaboration to make care fit can take place at the point of care, mostly during clinical encounters in which the patient's biomedical and contextual situation is taken into account, and at the point of life, mostly in the patient's personal environment. The patient is usually the one person bridging these 2 efforts, and whatever happens at the point of life remains to some extent invisible to clinicians if left undiscussed at the point of care. Tinetti and colleagues provide an exemplary quote from a patient with diabetes saying: "I do my blood sugar check every other day, every day is too much."³ To make the care plan fit within her daily routines, the patient modified it at the point of life. Nevertheless, this patient may be labeled as "noncompliant," a condemnatory term that is blind to the patient's context, reasoning, and work. It is precisely this context, reasoning, and self-management work that need to be brought into the clinical encounter to contribute to the cocreation of care that fits.

In the PPC program, the meetings between patients and their nurse or case manager may help to overcome the contextual blindness and contribute to making care fit, and the authors believe the identified goals can guide clinician decision-making. Rather than a conversation, this method may facilitate a staccato collaboration by which the patient provides goals and the clinician decides how to achieve those goals. Also, the method may not contribute to cocreation.

It is possible that in the spirit of efficiency, for example, the elicitation of priorities for documentation and feedforward networking will be coupled with a library of care plans and an algorithmic approach to determine which plan is a better match to the priorities of each patient.⁶ Tinetti and colleagues³ hint at the possibility of developing a comprehensive map of the broad but likely finite universe of goals and priorities linked to associated issues and connected with the interventions most likely to achieve those goals. This effort seems related to the traditional categorization of diseases and their adverse outcomes and the formulation of evidence-based recommendations to prevent them. Paradoxically, the application of algorithmic guidelines in response to "biological priorities" has contributed to polypharmacy and poorly fitted care, justifying in part the PPC program. How will patient priorities retain the personal context that gives them sense when documented in the medical record and used at another time and place to shape care without a new conversation? How will responding in this manner prevent us from once again missing the

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person in the patient? How will we ensure that responding to the documented priorities does not produce care plans that fail to make sense intellectually, practically, and emotionally to the patient?

Future work should uncover how priority elicitation can support the conversational dance of the patient and the clinician as they work together to continuously fit possible care plans. This approach can be seen as an elaborate cognitive and collaborative exercise, akin to trying on different clothes at the shop before taking them home. Clinicians and patients will need to consider patient priorities, the activities likely to advance them, and the extent to which their cumulative contribution to existing care will be helpful or burdensome in the patient's life. This complex analysis, however, seems feasible when conducted within a longitudinal partnership punctuated by critical and unhurried conversations.⁷

Rather than making the case for a comprehensive and complete map of patient priorities, the PPC program makes a strong case for how personal and contextual patient priorities can be. These priorities are likely to differ across patients with similar medical conditions and within the same patient over time, because they live with chronic conditions amid the tumultuous and exciting complexity of their lives. How to advance their care in a manner that makes intellectual, practical, and emotional sense is also likely to differ across patients with similar priorities and within the same patient over time. This process demands the ongoing elicitation and incorporation of patient preferences within continuous and complementary efforts—at the point of care and at the point of life—to integrate care and living. The PPC program has shown that eliciting patient priorities and using them to craft care is possible and effective. We need to shed light on the nature of the work of making care fit to ensure that it can effectively advance patient priorities while minimally disrupting their lives and loves.

ARTICLE INFORMATION

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