



# Will the implementation process for goal-oriented primary care succeed? A qualitative study investigating five perceived attributes of goal-oriented care

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## ABSTRACT

Throughout the western world, goal oriented care (GOC) is increasingly promoted as a strategy towards more person-centered, integrated care. The implementation of goal-oriented care not only takes place at the micro-level with individual primary care providers (PCPs) changing their approach, but also requires meso- and macro-level investment. In this study, we zoom in on experiences and actions of various meso- and macro-level actors that are actively engaged with implementing GOC, both within their organization or at the policy level. In-depth interviews were conducted with  $n = 23$  actors from a variety of different organizations (governmental institutions, provider organizations, patient organizations, health/social care organizations, primary care zones/care councils, etc.), using a semi- interview guide inspired by realist interviewing. Three main drivers for implementation were identified: recognition, commitment and coordination. On top of that, results were interpreted through Rogers' Diffusion of Innovations (DoI) theory in which five attributes are discussed that contribute to or hinder implementation success. Our findings can help define actions to support and facilitate the implementation process of an innovation such as GOC.

## 1. Introduction

Within various western countries, there is increased interest in goal oriented care (GOC) as a strategy to more person-centered, integrated care (De Maeseneer and Galle, 2023; Gray et al., 2020). Both on the provider level and the policy level, there is an increasing belief that patient goals instead of disease and problem-oriented targets should be the driving force of the process of care. Care that departs from patient goals will connect more to what matters to patients, which is especially important for the growing number of patients with complex care needs (Boeykens et al., 2022; Kuipers et al., 2019). Moreover, GOC shows potential to increase patient satisfaction and to lower healthcare costs (Bertakis and Azari, 2011; Mold, 2017).

At the clinical level primary care providers (PCPs) will need to acquire new skills in order to shift their current focus on disease and problem-oriented targets towards the patient's life goals (Boeykens et al., 2022; Purkale et al., 2020; Reuben and Jennings, 2019). Introducing tools that support GOC can facilitate the uptake of a goal-oriented approach (Singh et al., 2021). Fostering common values among interdisciplinary teams can further support PCPs to achieve this (Im et al., 2019). However, for sustainable implementation of GOC to be successful, adequate preconditions and structures need to be created. Implementing GOC care thus requires actions on the micro-level, but also meso- and macro-level preconditions need to be created. Valentijn et al., 2013 described this as system integration and organizational integration.

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Throughout this study, we investigate the implementation of GOC with a meso- and macro-level perspective. We adopt insights from Diffusion of Innovations (DoI) literature (Rogers and Williams, 1983) to identify factors that explain how and to what extent GOC is adopted in primary care practices. We depart from the assumption that both the inherent characteristics of the innovation itself as well as the extent to which the innovation fits with the context in which it takes place is important in comprehending the adoption of innovative practices (Huybrechts et al., 2021; Nilsen and Bernhardtsson, 2019). In this view, implementation efforts should be targeted towards the nature of the innovation itself and the context in which it is implemented.

### 1.1. The Flemish context

In Flanders, the Dutch-speaking region of Belgium, various initiatives on policy level as well as organizational level have been taken to support implementation of GOC. In particular, the concept of GOC was included in the Flemish primary care reform that was initiated in 2015–2019. With this reform, Flanders was geographically divided in 60 primary care zones in order to facilitate and support collaboration between local governments, PCPs and the person with care and support needs. Each primary care zone has a care council as its governing body. Additionally, the Flemish Institute of Primary Care has been established as the central contact point and as a platform for dialogue between primary care actors and the government. The implementation of GOC is supported by this institution, which has launched an open training course and piloted interprofessional trainings on GOC within different primary care zones, hereby disseminating this approach to local actors.

Moreover, the Fund Daniël De Coninck within the King Baudouin Foundation (KBF - a philanthropy foundation) invests in accessible, high-quality, humane primary care. In 2019, they initiated an International Learning Collaborative on GOC; a Summer Academy that for the first time did an in-depth exploration of the potential of GOC. Through their funding, the Primary Care Academy (PCA) was established: a research and teaching network of four Flemish universities, six university colleges, the White and Yellow Cross and patient representatives that has GOC as one of their main research topics. This fund also launched project calls specifically targeted to organizations in the field that aim to implement GOC. Furthermore, various organizations such as the Flemish Patient Platform (FPP) have been experimenting with GOC and tools have been developed to support its approach. As a consequence, the complex context of Flanders makes a good case to learn more about the implementation process of GOC.

### 1.2. Theoretical framework

Initiating a new approach and ensuring sustainable change is challenging. Implementation processes in primary care are complex and highly influenced by contextual variables (Nilsen and Bernhardtsson, 2019; Rogers et al., 2020). Rogers' DoI theory (2014) gives insight in the diffusion process of an innovation in which different actors pick up innovations at different speeds. Rogers identifies innovators, early adopters, early majority, late majority and laggards. Furthermore, assumptions are made on the determinants of why one innovation is successfully adopted, while others do not get picked up at all or only partially. According to Rogers et al. (2014), 49 to 87 percent of the variance in adoption rate of an innovation is explained by five perceived attributes: relative advantage, compatibility, complexity, trialability, and observability. Both quantitative, qualitative and mixed methods research in primary care demonstrates how looking into these five attributes can provide inside into the factors that affect the adoption rate of innovations (Carlford et al., 2010; Emami et al., 2018; Gueye et al., 2022; Helmink et al., 2012; Vedel et al., 2013). Therefore, we explore the main drivers of implementation as well as how these five attributes are viewed when applying the DoI theory to GOC.

## 2. Methods

Our aim is to gain in-depth insight into implementation processes of GOC in Flanders: how is overall engagement for GOC fueled and what drives its implementation forward? We depart from the experience of various meso- and macro-level actors that are active in (the implementation of) GOC in Flanders. The perspectives of these actors are very relevant because they are involved with the agenda-setting and are facilitating and mobilizing PCPs to start engaging with GOC. Research questions that emanate from the lived experiences of various actors are best addressed with qualitative research methods (Crabtree and Miller, 2022), as these provide insight in the “how” and “why” questions of implementation (Hamilton and Finley, 2019). We thus have conducted qualitative research with in-depth, semi- interviews. Firstly, we want to achieve a broad understanding on the overall drivers for implementation: what are the prerequisites for implementation of GOC? Secondly, we interpret findings through Rogers' DoI theory, as this will help gain insight in how the nature of the intervention affects its implementation.

### 2.1. Sample selection

Within primary care in Flanders, a variety of healthcare/social care organizations are active in GOC. They either include the concept in their strategic plans or have committed themselves to projects supporting the adoption of GOC. Our aim was to study real life implementation efforts, hereby recruiting respondents with a meso- and/or macro-level perspective on the implementation of GOC. For our purposive sample, we used the following inclusion criteria: 1) working in a health/social care context in which initiatives are taken to implement GOC, 2) working within the Flemish primary care context, 3) having at least 6 months of experience. Respondents could have different backgrounds (not only medical) and adopt varying roles in primary care contexts, such as being a staff member, a project coordinator, a policy maker etc. We hereby aimed for a purposeful sample with a maximum variation in the type of organization respondents were working in, such as different governmental institutions (e.g. the Agency of Care and Health on the Flemish level) and a variety of healthcare/social care organizations (e.g. an autonomous and integral home care service).

For the recruitment process, an overview of all possible stakeholders was made through the network of the PCA and our cooperating research team in Ghent, which has an extensive network of stakeholders active in the area of GOC. Respondents were identified through the network of the PCA, through a participants list of the Summer Academy on GOC in 2019 and/or through involvement in a KBS funded project. Additionally, a snowballing approach was used in which respondents could refer to other relevant stakeholders at the end of each interview. In some cases, we conducted paired interviews (Wilson et al., 2016) on condition they were complementary in terms of background, expertise and experience with the topic. Stakeholders were contacted by e-mail with information about the study and a request to participate. One reminder was sent in case of non-response.

Table 1 provides an overview of the respondents and their perspective on GOC.

### 2.2. Data collection

All interviews were planned between January and June 2022 and conducted by the first author – a sociologist trained in qualitative research methods. The interviews took place online using Microsoft Teams software and were audio-recorded and transcribed verbatim. A semi- interview guide was developed through expertise of the research team and inspired by realist interviewing (Greenhalgh et al., 2017). The following themes were included: 1) how is GOC interpreted in your organization and/or professional function; 2) how did it become an agenda item; 3) what actions were taken to propagate the concept of GOC; 4) what barriers and facilitators are experienced when

**Table 1**

Overview of respondents and type of organization.

| Respondent ID | Gender | Type of organization            | Perspective | Working in healthcare | Role                |
|---------------|--------|---------------------------------|-------------|-----------------------|---------------------|
| INT1          | Male   | Governmental institution        | Macro-level | 23 years              | Staff member        |
| INT2          | Female | Governmental institution        | Macro-level | 1 year                | Staff member        |
| INT3          | Male   | Governmental institution        | Macro-level | 17 years              | Policy officer      |
| INT4          | Male   | Governmental institution        | Macro-level | 20 years              | Policy officer      |
| INT5          | Female | Governmental institution        | Macro-level | 14 years              | Policy officer      |
| INT6          | Male   | Non-profit organization         | Macro-level | 20 years              | Consultant          |
| INT7          | Female | Umbrella organization           | Macro-level | 6 years               | Staff member        |
| INT8          | Female | Umbrella organization           | Macro-level | 13 years              | Staff member        |
| INT9          | Female | Provider organization           | Macro-level | 5 years               | Project manager     |
| INT10         | Female | Provider organization           | Macro-level | 13 years              | Project manager     |
| INT11         | Male   | Provider organization           | Macro-level | 21 years              | Chair               |
| INT12         | Female | Patient organization            | Macro-level | 8 years               | Policy officer      |
| INT13         | Female | Patient organization            | Macro-level | 15 years              | Director            |
| INT14         | Female | Health/social care organization | Meso-level  | 3 years               | Staff member        |
| INT15         | Male   | Health/social care organization | Meso-level  | 35 years              | Director            |
| INT16         | Female | Health/social care organization | Meso-level  | 16 years              | Coordinator         |
| INT17         | Male   | Health/social care organization | Meso-level  | 3 years               | Counsellor          |
| INT18         | Female | Non-profit organization         | Meso-level  | 2 years               | Project coordinator |
| INT19         | Female | Non-profit organization         | Meso-level  | 9 years               | Project coordinator |
| INT20         | Female | Primary care zone/care council  | Meso-level  | 17 years              | Coordinator         |
| INT21         | Male   | Primary care zone/care council  | Meso-level  | 8 years               | Staff member        |
| INT22         | Female | Primary care zone/care council  | Meso-level  | 1 year                | Staff member        |
| INT23         | Female | Primary care zone/care council  | Meso-level  | 4 years               | Coordinator         |

implementing initiatives for GOC. After the first, the second and the third interview, a debriefing with the entire research team was held to discuss the course of the interviews and to adjust the interview guide where it was deemed necessary. For all following interviews, an iterative approach was used in which the interview guide was slightly modified based on the topics and knowledge that came forward in initial analyses after the first data collection.

### 2.3. Data analysis

All results were thematically analyzed, supported by the software NVivo 12 ©. A combination of inductive and deductive analysis was used. Firstly, implicit and explicit ideas that came forward within the qualitative data were identified and described (Guest et al., 2011). We used a thematic content analysis (Hsieh and Shannon, 2005) to reduce the qualitative data by identifying core consistencies and meanings (Patton, 2002). These initial analyses and results were discussed with the broader research team (a multidisciplinary research team with backgrounds in sociology, medical sciences, social work, etc.) and further elaborated and analyzed by the main researcher. This resulted in the suggestion to utilize the DoI theory as described by Rogers et al. (2014) as a frame for deeper understanding of the data. Therefore, a second, deductive analysis followed on the raw data according to a sensitizing-concept approach. Sensitizing concepts are used as a frame of reference and direction, offering interpretative value in the qualitative research (Bowen, 2006). Thus, the attributes of an innovation (see:

**Table 2**

Perceived attributes of an innovation and their definitions (according to Rogers et al., 2014).

| Attribute          | Definition                                                                                                                                |
|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| Relative advantage | The degree to which an innovation is perceived as being better than the ideas it supersedes.                                              |
| Compatibility      | The degree to which an innovation is perceived as consistent with the existing values, past experiences, and needs of potential adopters. |
| Complexity         | The degree to which an innovation is perceived as relatively difficult to understand and use.                                             |
| Trialability       | The degree to which an innovation may be experimented with on a limited basis.                                                            |
| Observability      | The degree to which the results of an innovation are visible to others.                                                                   |

Table 2) as described the DoI theory provided a sense of direction as to what aspects of GOC are facilitating and/or hindering implementation. Frequent discussions within our multidisciplinary research team encouraged reflexivity: we all had our own lens to look at the data, but through dialogue and constant comparison with the data we made sure our analysis was grounded in the data. To enhance trustworthiness and credibility (Connelly, 2016; Morse et al., 2002), peer debriefing was done within our wider research team to explore whether the results correspond with their expertise and understanding of GOC processes. Furthermore, member checking was done by presenting our results in a summer school on primary care in 2022. As the audience consisted of actors with similar profiles as our respondents, their feedback on the presented results could be used to further reflect upon our results and to maintain credibility of our findings (Candela, 2019). Data analysis was done in the original Dutch language, but illustrative quotes were translated into English.

#### 2.3.1. Ethical approval

The study protocol was approved by the Medical Ethics Committee of the University of Antwerp / Antwerp University Hospital (project ID: 2021-3542). All participants received verbal and written information about the purpose and methods of the study and gave written informed consent.

### 3. Results

In total  $n = 23$  respondents were interviewed, among which  $n = 10$  respondents were interviewed in duo-interviews and one interview with  $n = 3$  respondents representing the same organization. Interviews were conducted with more than one person affiliated the same organization when the perspectives of both respondents were considered as complementary. For example, a senior employee who had a general view on how GOC became a topic of interest within their organization, combined with a junior employee who had more hands-on experience with project (s) on GOC. We received  $n = 6$  refusals to participate:  $n = 3$  had limited availability of time,  $n = 1$  was detached to another organization,  $n = 1$  felt they had too little affinity with the topic and we had  $n = 1$  non-response. The interviews lasted between 47 and 72 min.

#### 3.1. Overall drivers for implementation

As for the inductive part of our analysis, it became early on clear that

there is not one single, effective way to implement GOC, but there are however some “key ingredients” that seem to drive implementation efforts: recognition, commitment and coordination. Also noteworthy is that the diffusion of GOC seems to have a demographic component as well: respondents situated in the provinces of West-Flanders and East-Flanders seemed to be more aware of other actors’ initiatives and were often embedded in either a formal or informal network. Many innovators and active networks on GOC are situated within these provinces, which seems to evoke interest in actors that are situated nearby. Although our respondents mainly had a meso- and macro-level perspective on the implementation of GOC, they mentioned drivers, challenges and events on all levels (micro-, meso- and macro-).

Recognition in the context of GOC means that there is some type of acknowledgement, either formal or informal, that GOC is indeed worthwhile. For GOC to be implemented, some notion of recognition was often mentioned in one way or another during the interviews. Informal recognition can be about a perception or belief shared by PCPs that GOC is “good care”. It is about an overall conviction that this approach towards primary healthcare and towards their patients is desirable. More formalized, it can also be about a recognition of GOC as “quality of care” as defined on a policy level.

*In the end, our task is to work on the Flemish health objectives. If there is something in there about GOC, more primary care zones are going to say: “This is our mission, so we have to do something with this.” If on the federal or Flemish level nobody squeaks about GOC, then this choice has to be made individually. That’s a much bigger step. – [INT20, coordinator primary care zone]*

Commitment or being committed means that there is an agreement and active engagement to provide GOC and was seen as one of the main prerequisites for implementing GOC. This can be expressed on different levels. On the individual level, PCPs can be committed to integrate GOC within their way of working, but ideally commitment should also be expressed on an organizational and governmental level. Such commitment can be written down in strategic objectives of organizations and/or governmental institutions. But more importantly, commitment should be expressed and acted upon in concrete actions and initiatives.

*The fact that it’s written down gives us as a team credibility to thump the table and say: “we have all signed and endorsed this.. so help us think with us on how we can make this a reality.” – [INT4, policy officer governmental institution]*

Coordination is about organizing people and/or practices to work harmoniously according to a GOC approach. Different forms of coordination were mentioned, with the intent to keep GOC on the agenda within an organization and to create a structure in which GOC can happen. Some organizations had a dedicated person who took on a coordinating role with a specific focus on GOC and this was viewed as highly facilitating. But coordination can also be established through structures or systems: many respondents had high hopes for a “digital care and support plan”, a digital system that is being developed in Flanders that will include a section in which patient goals can be written down and information can be exchanged with other PCPs.

*It also stays alive because I have the role of care coordinator and I can put it on the agenda regularly. I think that’s not to be underestimated. Because otherwise, as a care provider, you quickly fall back into your old patterns. – [INT16, coordinator health/social care organization]*

### 3.2. Use of the theory of Diffusion of Innovations

As for the deductive part of the analysis, the five attributes as described in the DoI were used as our frame of reference to identify further elements that affect implementation efforts.

#### 3.2.1. Relative advantage

Relative advantage is “the degree to which an innovation is perceived as being better than the ideas it supersedes (Rogers et al., 2014).” Its importance was highlighted in the interviews, as more than half of the respondents stated (either directly or indirectly) that for GOC to be truly picked up by PCPs, the “what’s in it for me” needs to be underlined. Both intrinsic as well as extrinsic relative advantages were mentioned. The intrinsic relative advantages were considered to be the most important, especially the ones on a psycho-social level: more satisfaction from their job and a better care relationship with their patients.

*The organization is now fully on board and they tell us: “this really benefits us. It improves our relationship with the patient. We spend less time on it ... and the relationship with the caregiver is better.” – [INT1, staff member governmental institution]*

As for the more extrinsic relative advantages, the financial aspects of GOC were mentioned several times. It however seemed difficult to express clear expectations on how GOC relates to financial efficiency, both on an individual level and on a societal level. In individual daily practice, some argue that GOC can lead to efficiency gains when focusing on patient goals. On a more societal level, the importance of financial incentives for PCPs to truly adopt GOC were mentioned several times. The GOC approach does not always align with the current performance-based financing systems. This is viewed as a challenge for governments to create a driver to financially reward focusing on patient goals.

*Well, I don’t think we should be naïve about this if there is no funding in return. Those people are all working in a performance environment which is built upon receiving fees and so on. So people do expect something in return. – [INT3, policy officer governmental institution]*

#### 3.2.2. Compatibility

Compatibility is “the degree to which an innovation is perceived as consistent with the existing values, past experiences, and needs of potential adopters (Rogers et al., 2014).” Throughout our interviews, GOC came forward as a concept that strongly connects with both primary care organizations and individual PCPs. GOC was often described as a concept that expresses how one believes or feels primary care should be approached: “it suits us to a tee.” In this view, it is strongly compatible with the overall values and beliefs within a primary care setting. It was also argued that GOC makes abstract concepts such as person-centered care more concrete by providing practical tools and views about how to approach patients according to such views.

*People need to recognize it as valuable and meaningful ... and they have to recognize themselves in it. They have to be like: “Yes, indeed. This is exactly what I stand for.” – [INT17, counsellor health/social care organization]*

Often, organizations that are engaged with (implementing) GOC have already shown interest in other related concepts such as integrated care, person-centered care, positive health, value based or experience based care. GOC attracts those organizations that are already committed to shift away from a medical perspective or task-oriented approach towards a more person-centered approach.

*I also believe GOC is not an island on its own. I think it is related to integrated care, interprofessional collaboration, local community care, person-centered care, etc. These are all concepts that are very much alive and if you elaborate on that, you tend to end up with GOC. It combines all of these things and provides a way to really engage with these concepts. – [INT22, staff member primary care zone]*

As for compatibility with needs, respondents indicate that GOC can offer a perspective which can strengthen the vision of an organization that wants to offer person-centered care. GOC can provide guidance to actively carry such a vision and various respondents have ended up with GOC in search for a way to enhance collaboration within their



organization and/or to build bridges between different PCPs. Furthermore, it was mentioned that GOC can offer an approach that helps PCPs dealing with more complex care demands. However, there is a pitfall in merely using GOC when encountering highly complex patient cases in which they feel “stuck”. Lastly, GOC is seen as useful to address patients’ needs such as the desire to be heard. Yet, patients are not used to this approach and it was mentioned several times that a shift towards GOC requires a change in patient behavior as well.

*And well, GOC.. I’m not going to say that it is easy or that it’s the key to every door, but it does give you tools to tackle this. First, to make it a bit more manageable for yourself. Second, to truly depart from what is important to your patient and to understand why he or she has resistance.*  
– [INT16, coordinator health/social care organization]

### 3.2.3. Complexity

Complexity is: “The degree to which an innovation is perceived as relatively difficult to understand and use (Rogers et al., 2014).” The more complex an innovation is perceived by PCPs, the less likely it is to be adopted. It seems difficult to determine if GOC is perceived as rather easy or somewhat difficult. Throughout the interviews, opposing views were expressed: some viewed GOC as relatively easy to achieve, while for other it remained unclear how to start working with this approach. On the one hand, all of our respondents gave similar definitions of GOC, whereby the core message was that the approach is all about listening to patients and tailoring care to “what matters to them”. This is generally seen as something that comes quite natural to care providers. On the other hand, providing GOC does require a paradigm shift; PCPs have to detach from their focus on pathologies and have to shift their way of conversing with patients and how to enact upon their questions. This changes not only the type of conversations and treatment plans, but also how they position themselves as PCPs.

*It never ceases to amaze me how much difficulty there is about implementing GOC, when it is actually quite simple. It is just about listening to people.. and then translating that into a plan. And why is this so difficult? Because people are not used to it.* – [INT6, consultant non-profit organization]

Our respondents overall expressed enthusiasm and belief in the core ideas of GOC, but they also noticed that it remains quite theoretical and unclear how to apply it in daily practice. Because of this uncertainty about the concept, a wait-and-see attitude is often noticed. Tools for GOC could give PCPs more concrete guidance for approaching their patient in a goal-oriented manner. However, the appropriate use of these tools are also questioned: which tool(s) best fits with the own needs? What tool should be used in what circumstances? Are these tools interchangeable?

*In our project on GOC, we put a big question mark behind the tools. What is the correct value of these tools? And well, how do we have to approach this? We do know the tools ... but what do they have in common? Are they alternatives for each other? Or do they complement each other?* – [INT11, chair provider organization]

### 3.2.4. Trialability

Trialability is: “the degree to which an innovation may be experimented with on a limited basis (Rogers et al., 2014).” Being able to try-out innovations and to find out how it fits into their own practices can win PCPs over to implement it. As there is still much unclearness on how exactly to integrate a GOC approach, this offers space to experiment with a “trial-and-error” attitude, benefiting the trialability of the intervention. By putting the approach into practice and finding out how it works within PCPs own way of working, the original concept gets further shaped by the PCPs themselves. To surface this attitude of trying out and experimenting with the concept, PCPs need to have the courage to come out of their comfort zone and to try out different conversational

techniques that are new to them. In turn, organizations in which PCPs operate, are required to have a learning culture in which there is openness towards this approach and that there is psychological safety to experiment with this.

*That time and space to make mistakes, to learn, is really needed to put a new care concept into practice. This may be missing a bit within our organization. Despite the will. Despite the priority. But this is something you can only achieve with your people. You can’t go and do it alone.* – [INT14, staff member health/social care organization]

The trialability of GOC can consist of experimenting with the wide variety of tools that exist. The tools can be a way to make the concept of GOC more concrete. The choice of a certain tool is often coincidental (the one they were introduced to), if been offered different tools they prefer the one that aligns with their way of working. Participants also mention that once they have enough experience and feel confident with their goal-oriented conversation, they can work without it.

*We noticed that everyone chose the tool to which they had the most connection with. But often, those tools were also quickly released. They used it to start a conversation and then they went on and made their own conversation.* – [INT1, staff member governmental institution]

According to several respondents, merely educating PCPs on a GOC approach is not enough. They have to incorporate it in their work and that of their colleagues. A helpful way is to connect GOC with concrete practices or systems within an organizations, for example addressing it in multidisciplinary consultations or having a digital system to write down patient goals. It is also recognized that making the shift towards GOC is a process “in which the minds of people must grow.” Intervention in peer groups is also often mentioned as an important facilitator: real-life cases can then be discussed and the way GOC can be of value can be stressed out more vividly.

*What we experience to be tremendously facilitating are those care providers who are really on board. If you have colleagues within your organization who have integrated the approach, who are playfully experimenting with it, this has a very contagious and inspiring effect on others.* – [INT15, director health/social care organization]

### 3.2.5. Observability

Observability is: “the degree to which the results of an innovation are visible to others (Rogers et al., 2014).” In the context of this research, it means that GOC needs to be more than just a vision on how to provide care. According to our respondents, the concept of GOC is often intertwined with other concepts such as person-centered care or customized care, which tend to be viewed as less actionable. Our respondents generally experience that PCPs are in favor of the concept of GOC, but implementing it in practice is more difficult. Yet they are aware that it only becomes meaningful when it is actively applied within primary care practice.

*The thing that I’m really allergic to are those entrance halls where you can find various posters that are basically meaningless. Values only become valuable when they are experienceable in practice. Otherwise, it’s bullshit. So GOC only becomes purposeful if it is translated into practice.* – [INT17, counsellor health/social care organization]

For GOC to become observable to the PCP, it is key that they experience its outcomes firsthand. There is the need for PCPs to interact with each other about specific encounters in which goal-oriented conversations were held. Another initiative is to share and discuss “inspiring practices”. By collecting stories of how PCPs “truly made a difference for their patient” the different ways in which goal-oriented approaches can manifest itself are shown. They argue it will strengthen the belief in the value of the approach, which in turn will encourage PCPs to further experiment with it. Thus, observability is all about making the GOC approach actionable and the outcomes visible.

Above all, our health care providers now have the feeling that GOC can actually mean something. Before it was just a theoretical concept they stood behind of. But now we are at the tipping point of experiencing: “this actually means something throughout the care for my patient.” – [INT20, coordinator primary care zone]

#### 4. Discussion

Implementing GOC requires implementation efforts that are targeted towards the nature of the intervention itself and the context in which it will be implemented. The implementation of GOC mostly takes place on the micro-level with PCPs focusing on patient goals and values, but it also requires meso- and macro-level investments. In this study, we zoomed in on real life implementation efforts of various meso- and macro-level actors with an organizational or policy perspective. In-depth interviews with  $n = 23$  respondents contributed to our understanding of the overall drivers of implementation as well as the attributes of the innovation itself that contribute to implementation success. Within our study, three overall drivers came forward to enhance the implementation of GOC, as well as five DoI attributes of GOC that are key when it comes to implementation success.

##### 4.1. Drivers and attributes of GOC

The overall drivers are recognition, commitment and coordination and can be viewed on the micro-, meso-, and macro-level, as demonstrated in Table 3. Firstly, recognition refers to some type of acknowledgement that GOC is worthwhile. This can be informally, when there is a shared perception or belief that GOC equals “good care”. It can also be more formally, when GOC is recognized on the policy level as “quality of care”. Within literature, authors such as Mold (2017, p. 5) argue that if only we would define quality of care as “care likely helps patients achieve their goals”, GOC would be considered higher quality than disease or problem-oriented care. Recognizing that focusing on patients’ life goals is vital in providing “good care” emphasizes that GOC is indeed desirable, which promotes its adoption.

Second, an active commitment needs to be created, which can be expressed on different levels. It can be a written commitment when GOC is included in strategic objectives of organizations and/or governmental institutions. But to truly make it an active commitment, GOC should be acted upon in daily practices. In this respect, various research shows that collaboration of opinion leaders or local champions are a driving force in order to obtain the commitment of PCPs (Flodgren et al., 2019; Miech et al., 2018; O’Reilly et al., 2017; Vedel et al., 2013). The innovators and early adopters can play a crucial role in further spreading the innovation.

**Table 3**  
Integrated findings on the three main drivers for implementation of GOC.

|                     | Micro-level                                                                                      | Meso-level                                                                                                                    | Macro-level                                              |
|---------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| <b>Recognition</b>  | Recognition of GOC as an essential part of “good care” by individual PCPs.                       | Recognition of GOC by organizations as an essential part of “good care”. Expressed on strategic level and in daily practices. | Recognition of GOC as “quality of care” on policy level. |
| <b>Commitment</b>   | Highly enthusiastic PCPs can become ambassadors or champions.                                    | Explicitly including GOC in the strategic vision of the organization.                                                         | Representation of GOC in policy objectives.              |
| <b>Coordination</b> | Individuals explicitly taking up the task to support and encourage GOC and put it on the agenda. | Providing time and means for individuals to take up activities to support and/or promote GOC.                                 | Embedding GOC in existing systems and/or platforms.      |

Thirdly, some type of coordination has to be set up to facilitate a GOC approach. This should contribute to making GOC an agenda item in teams and in interactions between patient and PCP. A person can be committed to achieve this, or an organization can create structures in which GOC is facilitated within communication channels and routine practices. Coordination can also be achieved through intervention with peer groups and the sharing of best practices, which closely relate to the concept of Balint groups (Ryding and Birr, 2022) or quality circles (Rohrbasser et al., 2018). Interaction in these kind of peer groups can positively influence professional role perception and thus facilitate the paradigm shift that is needed to provide GOC (Rohrbasser et al., 2018; Ryding and Birr, 2022).

Besides these three overall drivers for implementation, further actions to implement GOC can be targeted towards the learnings of each DoI attribute. A synthesis of our findings and how they can manifest on the micro-, meso- and macro-level is presented in Table 4.

The attribute relative advantage states the importance of conveying the “what’s in it for me.” PCPs need to be convinced about an innovation’s advantages. According to Richter et al. (2021), what PCPs acknowledge as the benefits of an innovation is driven forward by their personal values. They distinguish between patient-oriented values and economic-oriented values. As the perceived advantages of GOC are mostly situated on a more intrinsic and psycho-social level, this would suggest that the innovation would mostly appeal to PCPs with mainly patient-oriented values. Relative advantage together with observability are arguably the attributes that are most explanatory for implementation success (Scott et al., 2008).

For compatibility, it implies that an innovation is more compatible with their way of working or thinking. High compatibility improve the chances of successful implementation. Shifting from a problem-oriented medical paradigm to a person-centered paradigm fits the current needs of patients and clinicians. According to Mold (2022), this can provide answers to current burdens and challenges experienced in primary care, such as clinician burnout, patient dissatisfaction, non-adherence, over-diagnosis etc. Furthermore, we learned that some organizations discover and start engaging with GOC as it strengthens interprofessional collaboration, care coordination and/or patient empowerment. The concept can also be linked or woven into guidelines or tools, such as the BelRAI or the SCIROCCO tool. To further support the implementation of GOC,

**Table 4**  
Integrated findings on the DoI attributes.

|                           | Micro-level                                                                                               | Meso-level                                                                                         | Macro-level                                                                       |
|---------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| <b>Relative advantage</b> | Increased job satisfaction, better relationship with patients.                                            | Efficiency gains at organizational level.                                                          | Efficiency gains at societal level.                                               |
| <b>Compatibility</b>      | Alignment with PCPs individual role perception and values. Fit with patient needs.                        | Alignment with the vision and values of an organization.                                           | Alignment with the desire to go towards integrated, person-centered primary care. |
| <b>Complexity</b>         | Defining what it means to a PCP to provide GOC.                                                           | Defining which tools best fit what settings.                                                       | Creating an overall paradigm shift.                                               |
| <b>Trialability</b>       | Further shaping the concept of GOC to fit with PCPs own way of working. Stepping out of the comfort zone. | An organizational culture that facilitates experimenting (psychological safety).                   | Creating structures that allow for interaction between PCPs about patient goals.  |
| <b>Observability</b>      | Stimulate interaction between individual PCPs about GOC.                                                  | Enabling discussion about GOC through intervention. Collection and sharing of inspiring practices. | Defining GOC as a stepwise process that facilitates integrated care.              |

initiatives should actively seek out connection with existing values, ideas and needs in the setting where it gets implemented. Throughout our analysis, the attribute of compatibility seemed very broad, as it can refer to compatibility with values and beliefs, with previously introduced ideas, with needs. Overall, the attribute connects strongly to the necessity to study contextual determinants in implementation research, which is underlined in many implementation research (May et al., 2016; Nilsen and Bernhardtsson, 2019; Pfadenhauer et al., 2015).

The attribute of complexity states that the more complex an innovation is perceived, the less likely it is to be adopted. This is why for each PCP it should be clarified “*what does it mean to me to provide GOC?*”. Boeykens et al. (2022a,b) have unraveled different stages in GOC which could help PCPs to understand and act according to GOC principles: goal-elicitation, goal-setting, and goal-evaluation. The authors argue that further research should focus on the process of goal-setting and how this knowledge could be translated into a tangible workflow for GOC (Boeykens et al., 2022). This could eventually lead to a better sense of “*what is expected of me?*”, lowering the perceived complexity.

The attribute of trialability assumes that an innovation can only gain meaning when people actively try it out and experiment with it, hereby discovering how it can fit within their own way of working. This is especially important for the early adopters of an innovation (Rogers and Williams, 1983). Experimenting with GOC can be explored by initiating a different type of conversation, but can also be supported with existing tools that can guide these conversations. Different tools will connect to different types of patients and caregivers, depending on the style of the PCP, the setting where care takes place, interests/capabilities of the patient, etc. To enhance trialability, it is key to create a safe learning environment in which PCPs can experiment and interact with each other about what works for them.

When it comes to observability, it is important to make GOC outcomes visible by encouraging discussion of cases and best practices in intervision with peers. Furthermore, it is also argued that research evidence supporting the innovation must be clearly visible (Scott et al., 2008). For GOC this is however tricky, as hard evidence on the advantages of GOC does not exist yet. To enhance further observability and embeddedness in primary care practices, the concept of GOC should be translated into a practice-based intervention that allows for deeper understanding of the concept and a stepwise approach to get started with it.

#### 4.2. Strengths and limitations of our research

A variety of respondents with different backgrounds and perspectives were interviewed in Flanders about their experience with real life implementation efforts for GOC. This allows for a meso- and macro-level perspective on GOC initiatives, enhancing our understanding of how an innovation gets adopted by different organizations and governmental institutions and what is needed to further integrate the approach in primary care. However, data triangulation in which observations or document analysis complement the findings from in-depth interviews could have expanded our understanding of the implementation dynamics. Subjective perceptions of respondents could then be verified and the overall dynamics and vision of the organization could be disconnected from any personal interpretations of GOC.

A great asset of this study is that our findings contribute to a better understanding of implementation processes in general and their success factors. Insight in the overall drivers and attributes of GOC can help defining further actions for sustainable implementation. However, an intervention can be viewed as having different components, with the intended change, the context and the implementation strategies as its main building blocks (Huybrechts et al., 2021). In this manuscript, we have now focused on the broader drivers and how the nature of the intervention affects implementation success. To capture a more complete view on how to understand the implementation process of GOC, contextual factors should be examined as well. Such contextual factors

can also be linked to certain attributes of an innovation: e.g. compatibility of GOC will be higher in a setting where there is already much interest in providing person-centered care.

Recent studies have already captured micro-level perspectives on our research subject, investigating how PCPs themselves view and operationalize GOC (Boeykens et al., 2022) and aiming to understand patient experiences of goal-oriented approaches (Boeykens et al., 2023). However, these studies are not focused on the underlying implementation processes. For a more complete understanding, a parallel study should be considered in which the views and experiences of both PCPs and patients are investigated within those organizations/settings that are experimenting with GOC. Furthermore, we should also consider that this study is limited to the Flemish landscape and that the dynamics of this region might differ from other regions or countries. A repeated study on a broader, international level can learn us whether similar drivers are identified in different countries and to what extent our findings are region-specific or can be generalised.

Another important consideration is that our sample only includes the innovators (e.g. those who have developed tools to facilitate goal-oriented conversations) and/or early adopters for GOC. Within the Flemish primary care landscape, the innovation of GOC has yet to be picked up by the early majority. Subsequently, we might have captured a more positive view of how the DoI attributes are perceived and interpreted. Previous research suggests that later adopters are less positive about the attributes of an innovation than earlier adopters (Vedel et al., 2013). Future research could thus include early majority, late majority or laggards perspectives on the same innovation to compare in what way they view the attributes differently. This is especially important later on in the translation phase and the sustainment phase of the implementation process (Huybrechts et al., 2021). Throughout our analysis, we weren't able to distinguish how mature or experienced each of the represented organizations were in implementing GOC. This is firstly because the concept of GOC often intertwined with other concepts such as positive health or person-centered care, which it made it difficult to pin-point when a focus on GOC was adopted. Secondly, a time span in which GOC was adopted often didn't correspond with how far in the implementation process they were. Thirdly, our sample consists of various types of actors and a maturity level on the implementation process was difficult to give for macro-level actors, who's main role was to facilitate implementation processes. A study design that made it possible to distinguish between the different implementation phases could have contributed to our understanding.

#### 5. Conclusion

Implementation processes in primary care are complex and implementation success depends on several factors. Creating recognition, commitment and coordination appear to be three important ingredients that drive forward the implementation process of GOC. Furthermore, looking into the five attributes of an innovation as defined by Rogers et al. (2014) can help us define actions to support and facilitate the implementation process of an innovation such as GOC. Further research can dive deeper in how the attributes of an innovation differ throughout different types of adopters (e.g. early adopters versus late majority) and how they relate to different contexts.

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#### Ethical statement

The study protocol was approved by the Medical Ethics Committee of the University of Antwerp/Antwerp University Hospital (project ID:



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### Author contributions

I.H. wrote the main manuscript text. A.D., E.V., P.B., P.R. and S.A. contributed to the different steps of the making of this manuscript. All authors reviewed the manuscript.

### Declaration of competing interest

The authors declare that there is no conflict of interest.

### Data availability

The authors do not have permission to share data.

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## Glossary

- BelRAI**: the Belgian implementation of the interRAI assessment tools. RAI stands for resident assessment instruments; these are scientifically validated instruments enabling an assessment of the degree of dependency and the care needs of individuals.
- Dof**: Diffusion of Innovations (theory)
- FPP**: Flemish Patient Platform
- GOC**: goal-oriented care
- KBF**: King Baudouin Foundation
- PCA**: Primary Care Academy
- PCP**: primary care provider
- SCIROCCO**: an online self-assessment tool with an objective to assess a region's readiness for integrated care.