

Client-centered practice in rehabilitation: definition, instruments and challenges

Prática centrada no cliente na reabilitação: definição, instrumentos e desafios

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<http://dx.doi.org/10.11606/issn.2238-6149.v28i1p122-127>

Vaz DV, Jubilini LG, Queiroz LC. Client-centered practice in rehabilitation: definition, instruments and challenges. Rev Ter Ocup Univ São Paulo. 2017 Jan.-Apr.;28(1):122-7.

ABSTRACT: *Introduction:* in rehabilitation, a patient's ability to cope with a health condition, make decisions, find motivation and adhere to treatment are essential to therapeutic outcomes. Client-centered practice (CCP) recognizes and promotes patients' interests as central to care delivery. CCP is essential for the advancement of rehabilitation. *Objectives:* i) identify the fundamentals of CCP, ii) describe clinical instruments available for implementing it, iii) register CCP results obtained so far, iv) analyze the main barriers and benefits of CCP. *Methods:* narrative review of literature from databases and reference lists. *Results:* based on reviewed studies, CCP is a collaborative approach to clinical practice that aims to empower patients and recognize them at the center of the decision making process, in order to deliver better care. Several simple instruments can be immediately used in clinical practice. Few studies have investigated effects of CCP in rehabilitation. Challenges at the individual level of therapists and patients as well as at the institutional level of health services need to be met in order to implement CCP.

KEYWORDS: Patient care planning; Rehabilitation; Review.

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RESUMO: *Introdução:* Na reabilitação, a habilidade do paciente em lidar com a sua condição de saúde e tomar decisões, sua motivação e sua adesão, são determinantes para os desfechos terapêuticos. A *prática centrada no cliente* (PCC) reconhece e promove a centralidade dos interesses de pacientes e por isso seu conhecimento é fundamental para o avanço da reabilitação. *Objetivos:* i) identificar os fundamentos da PCC, ii) descrever instrumentos para sua implementação, iii) registrar resultados da PCC, e iv) analisar as principais dificuldades e benefícios da PCC. *Método:* Revisão narrativa a partir de bancos de dados e cruzamento de referências. *Resultados:* segundo estudos revisados, a PCC é uma abordagem clínica colaborativa e empoderadora do paciente, que reconhece-o no centro do processo decisório, aumentando a adequação do cuidado. Diferentes instrumentos simples podem ser imediatamente adotados na clínica. Ainda poucos estudos documentam resultados da PCC na reabilitação. Para implantação da PCC é necessário vencer desafios no nível individual de terapeutas e pacientes e no nível institucional de serviços de saúde.

DESCRITORES: Planejamento de assistência ao paciente; Reabilitação; Revisão.

This study started as an undergraduate monograph.

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INTRODUCTION

In rehabilitation, a patient's ability to cope with a health condition, make decisions, find motivation and adhere to treatment are essential to therapeutic outcomes. Client-centered practice (or patient-centered care), hereinafter referred to as CCP, is a model of practice that takes all these factors into account. The empowerment of patients and family members for effective participation in the definition of therapeutic goals is paramount in this model of practice. We believe that knowledge of CCP is central to the mission of Physical Therapy and Occupational Therapy to meet patients' demands with quality. Thus, this review aims to: *i*) identify the fundamentals of CCP, *ii*) describe tools used to implement CCP, *iii*) review evidence of its effects, and *iv*) analyze the challenges faced in implementing it.

REVIEW METHODS

Searches were carried out on *PubMed* and *Google Scholar* with combinations of the terms "patient centered care," "client-centered practice," "physical therapy," "physiotherapy," "occupational therapy," "rehabilitation." 36 studies were selected, based on their titles, as potentially relevant. After reading the abstracts, 20 studies were selected. Relevant references from these studies were also included.

During the literature review, we observed profuse literature on CCP from Occupational Therapy. The principles of CCP appear to have been instilled in occupational therapists' professional training and culture, more than any other rehabilitation professionals¹. Evidence and analyses presented in this literature are very relevant to both Occupational Therapy and Physical Therapy, since these professions often work together and serve similar populations. The two professions differ in their *cores*, but share *fields*. On the one hand, the core is the combination of knowledge and practice that is specific to each profession and defines its identity. The field, on the other hand, refers to settings with imprecise limits where professions support each other in fulfilling their theoretical and practical tasks². Therefore, we reviewed studies from both areas. Next, we present the review results for the objective *i*): identify the fundamental elements of CCP.

RESULTS AND DISCUSSION

Definition of CCP

The recognition that each patient may present unique responses for a given health condition puts the client, his/her context and personal perspective at the center of the therapeutic process. Given the patient's centrality, CCP can be defined as *a clinical approach based on respect and partnership with clients, that recognizes their autonomy, their need to make their own choices about the care they receive, their privileged experience about their health condition, and their potential to contribute to the therapeutic process*. This approach seeks to provide accessible services appropriate to the particular context in which the customer lives^{3,4}. In short, the CCP is a collaborative approach that seeks to empower patients, placing them at the center of decision-making process to increase the quality of therapeutic care. From the evaluation, to choice of goals and intervention methods to documentation of results, the patient's values and preferences are crucial.

However, gaps between patients' and clinicians' values and preferences are documented, especially for physical therapists and their patients. On the one hand, traditional models of treatment prioritize remediation of deficits in structures and functions of the body, such as muscle strength and range of motion. On the other hand, patients wish to improve their performance in activities they consider essential for their physical, psychological and social well-being⁵. Correction of deficits may be necessary to therapy, but it cannot be its ultimate goal, because it is not sufficient for the promotion of patients' interests. In CCP, these interests are central to the therapeutic process. To identify patient's interests and set therapeutic goals, as well as to define ways to monitor results, several standardized tools are available. They are characterized in the following section, as the objective *ii* of this study.

Tools for implementing CCP in rehabilitation

The following instruments are all based on interviews to define patients' interests and goals. In some situations, the therapist may consider such goals inappropriate or unrealistic. However, as CCP is a therapist-patient partnership model, there must be openness to discussion and collaboration. In other situations, the therapist may consider a patient's perception about his or her situation is distorted.

Nevertheless, patients generally have great judgment about their functional difficulties⁶. Family members or caregivers can also be interviewed as proxies for these patients or for infants, small children, or patients with severe cognitive deficits⁶. Interviews for goal setting may also be inadequate when immediate, short or local intervention like postoperative mobilization or pulmonary hygiene is needed.

Goal Attainment Scaling

Goal Attainment Scaling (GAS) is a widely used tool that combines goal setting in partnership with the patient with the possibility to analyze results of therapy. It is used in several clinical settings, regardless of patient diagnosis. The GAS is applied in five steps⁷. In the first step, the patient defines his/her main activity difficulties and goals, and can include as many activities as he/she wishes. Goals must be relevant to the patient, easy to understand, measurable, related to performance of functional activities and achievable within a predefined time⁷.

In the second step, the patient assigns importance and difficulty scores (ranging from 0 to 3) to each goal. Zero means no importance or difficulty and 3, maximum importance or difficulty. If the patient assigns any goal as 0, this goal must be renegotiated and replaced by another one of greater priority.

In the third step, expectations of functional performance after treatment are set. These expectations must be realistic, likely, and written in the most specific language possible. Therefore, at the end of treatment, there will be clear and measurable performance criteria that will define if the expectation was achieved or not.

In the fourth step, a performance scale is created ranging from -2 to +2 : 0 (zero) corresponds to the expected result defined in the third step; -1 and -2 correspond to a results below and far below expectation; +1 and +2, results beyond and far beyond expectation. These levels should cover clinically relevant and approximately equal change intervals. Usually, the level -1 or -2 represents the patient's current performance.

In the final step, after results of therapy are classified in levels -2 to +2, a total score can be calculated. This calculation involves the value of performance before and after the treatment, as well as the values of difficulty and importance.

GAS is a valid and useful tool to facilitate CCP. It can be applied in about 30 minutes. The main mistakes that compromise its use are setting of unrealistic goals,

with little progression between levels and insufficient criteria to differentiate one level from the other. Practical examples are available for better understanding of the method⁷.

Canadian Occupational Performance Measure

The Canadian Occupational Performance Measure (COPM) was developed by occupational therapists and is also used in physical therapy practice. It focuses on documenting functionality in three performance areas: self-care, productivity and leisure⁶. In a semi-structured interview, patients identify occupations, activities or tasks they find difficult in three performance areas. The COPM form lists several activity suggestions to help patients analyze their functional issues comprehensively.

After the interview, optionally, the patient assigns importance grades ranging from 1 to 10 for each task. The five most important tasks are elected the goal of therapy. Then, for these goal-tasks, patients assess their performance and satisfaction levels with grades varying from 0 to 10. Overall performance scores are given by the sum of grades of each task, with the total divided by the number of tasks. The same procedure is used for overall satisfaction scores. New scores can be calculated after the intervention for documentation of progress. Differences of two or more points are considered to be clinically significant. Several studies demonstrate the validity, reliability and sensitivity of the COPM⁶.

Patient-Specific Functional Scale

The Patient-Specific Functional Scale (PSFS) was developed especially for patients with musculoskeletal disorders and consists of an interview in which the patient selects five important activities he/she finds difficult or impossible to perform due his/her impairments or health problem. For each activity, the patient assigns a difficulty grade from 0 ("unable to perform the activity") to 10 ("able to perform the activity as well as before the injury or problem"). In subsequent assessments, the patient reassigns grades to the same activities, or identifies new activity limitations that have arisen over time. The PSFS has an excellent reliability and validity⁸.

Patient Goal Priority List

This instrument consists of a list of priorities, developed especially for patients with musculoskeletal disorders and persistent pain. First, patients list

activities (any number of them) they find difficult to perform. Then, they rank these activities by priority. Afterwards, they define how often (daily, weekly or monthly) each activity is performed. Finally, they rank activities by level of difficulty. The goal-activities for therapy are those 4 or 5 activities that reach the top of the lists of difficulty, priority and frequency. Validity and reliability of this listing method was not specifically analyzed⁹.

Effects of CCP in rehabilitation

A study with patients with traumatic brain injuries (TBI) has shown that goal setting in CCP provides structure for rehabilitation, gives focus to therapy, increases motivation of patients and therapists, and promotes satisfaction with results¹⁰. CCP can also reduce anxiety¹¹, improve the sense of self-efficacy and autonomy, and increase participation in the rehabilitation process¹⁰. These are important effects, since they can relieve the distress that normally comes with health problems.

There is also some evidence that CCP promotes functional performance gains. Patients with TBI with high involvement in goal-setting had significantly better performance at the end of a OT treatment program¹² when compared to patients with low involvement. For patients with rheumatic disorders in physical therapy treatment, patients that participated in collaborative goal-setting obtained greater progress in functional skills, pain, range of motion and muscular strength¹³. Similar results were found for functional independence and self-care after occupational therapy treatment in patients with various health conditions¹⁴.

However, other studies have not observed differences between groups that participated or did not participate in the collaborative goal-setting^{15,16}. In addition, a study found worse results for fatigue and quality of life of patients with multiple sclerosis who received client-centered occupational therapy services compared to the usual approach¹⁷. PCC requires that more time be used on consultation with patients. It is possible that excessive time was spent on evaluations and meetings with patients, with insufficient time for actual treatment. The issue of time allocation needs to be considered in the analysis of CCP effects.

Challenges for implementation of CCP

Barriers to the CCP occur both at the individual and the institutional levels, for therapists and patients.

Recognition of these barriers is vital for overcoming them. The literature provides some suggestions.

For therapists, many barriers relate to their poor communication and negotiation skills¹⁸. Other barriers are attitudinal: some physical therapists believe they already do, or have always done CCP¹⁹, despite the evidence of gaps between what patients want and what therapists offer, and the documented low ability of therapists to share their power in making decisions. It is important to understand that CCP is an open process and can always be improved. Finally, some therapists report that they feel afraid to share their power with patients and their families and fear losing prestige and recognition when they need to adhere to the CCP²⁰.

Certainly, adherence to CCP requires therapists to abandon the role of experts with full power to make diagnostic and therapeutic decisions and move the role of patient's partners or consultants. Some professionals fear that this role change may lead to devaluation of the scientific and technical knowledge of occupational and physical therapists. CCP often requires that professionals expand the focus of their work to accommodate patient's interests, crossing typical professional boundaries and integrating fields of expertise, as mentioned earlier. Some clinicians have expressed discomfort with this expansion, wondering if it does not imply in loss of their original professional identity. Interestingly, while clinicians perceive this as a disadvantage, patients often identify it as one of the main CCP advantages^{19,20}. This tension reflects broader theoretical and historical issues related to the evolution of professional identities.

Finally, clinicians may perceive tensions between CCP and evidence-based practice because of its ethical imperative to provide patients with the treatment best supported by evidence, given the available resources and the client's preferences. Physical therapists working in CCP services reported feeling some pressure to continue therapies that had no evidential support but were requested by families, and feared that their work would lead to poor outcomes for patients^{19,20}. This conflict relates to the limits of knowledge provided by randomized controlled studies, whose applicability may be limited in the highly individualized context of each patient. Discussion of these issues, as well as clinical practical education under principles of CCP, should be part of professional education. Even short educational programs (of a few hours, thus more easily incorporated into previously structured curricula) can produce improvements in skills and beliefs of health professions students about shared decision-making²¹.

Patient barriers most often include deficits in cognition, expression, memory and self-perception²². Some patients may not fully understand their difficulties and have unrealistic perceptions of their prognosis. This raises some questions. Who is the client in CCP? Is every customer able to make decisions about their care? What to do, for example, when a bedridden and depressed older adult does not want to engage in any activities proposed by the therapist? One answer extends the concept of client to include family members and caregivers, who can and wish to participate in therapeutic decisions⁶. Another answer involves the recognition that some patients wish to and can articulate their needs and direct decisions, others are not always in a position to take on such power and need to be guided. Patients have the right to assume responsibility, as well as the right not to take responsibility. Empathy to discern between situations is fundamental to CCP.

Lastly, barriers at the institutional level are of great importance, because structural factors can shape the actions, thoughts and feeling of individuals – therapists and patients. Common barriers include standardized (and not individual) limits in the number of therapeutic sessions; limited service scope, that make home, school or workplace visits unfeasible; absence of team-work so that different clinicians can't work together to plan and execute customized therapeutic projects even when they include techniques and resources normally considered to be outside their typical professional repertoire. CCP

demands changes in the culture of organizations and health professions. There are several assessment tools that can be used to characterize the degree of “centrality” on the client, either at the institutional level or at the level of individual clinicians and patients^{21,23-,25}. Training of professionals involves financial investments, but over time, the benefits can exceed costs¹⁹.

FINAL CONSIDERATIONS

This study provided a narrative review of CCP fundamentals, tools that can be used to implement it, effects documented to date, as well as the main difficulties and benefits of its adoption in rehabilitation. It must be emphasized that CCP is not limited to any procedures, and therefore cannot be defined by adoption of instruments or specific evaluation or treatment techniques. Instead, CCP is characterized by a set of individual and institutional attitudes and values in relation to the entire clinical process. Such attitudes and values include consideration of the patient as an equal inside the health team, enhancement of communication – which involves listening and educating patients – and an openness to have patients participate as much as they want in decision-making, so that they can make the choices most appropriate to their particular life context. Knowledge of the CCP is central to the professional mission of Physical therapy and Occupational Therapy to meet patients' demands and offer care with quality.

REFERENCES

1. Rosewilliam S, Roskell CA, Pandyan A. A systematic review and synthesis of the quantitative and qualitative evidence behind patient-centred goal setting in stroke rehabilitation. *Clin Rehabil.* 2011;25(6):501-14. doi: 10.1177/0269215510394467.
2. Campos GWS. Saúde pública e saúde coletiva: campo e núcleo de saberes e práticas. *Ciênc Saude Coletiva.* 2000;5(2):219-30. doi: 10.1590/S1413-81232000000200002.
3. Law M, Baptiste S, Mills J. Client-centred practice: what does it mean and does it make a difference? *Can J Occup Ther.* 1995;62(5):250-57. doi: 10.1177/000841749506200504.
4. Sumsion T, Smyth G. Barriers to client-centredness and their resolution. *Can J Occup Ther.* 2001;67(1):15-21. doi: 10.1177/000841740006700104.
5. Allen DD, Talavera C, Baxter S, Topp K. Gaps between patients' reported current and preferred abilities versus clinicians' emphases during an episode of care: any agreement? *Qual Life Res.* 2015;24(5):1137-43. doi: 10.1007/s11136-014-0888-0.
6. Law M, Baptiste S, Carswell A, McColl MA, Polatajko H, Pollock N. Medida canadense de desempenho ocupacional (COPM). Trad. Livia de Castro Magalhães, Lilian Vieira Magalhães e Ana Amélia Cardoso. Belo Horizonte: Editora UFMG; 2009.
7. Bovend'Eerdt TJ, Botell RE, Wade DT. Writing SMART rehabilitation goals and achieving goal attainment scaling: a practical guide. *Clin Rehabil.* 2009;23(4):352-61. doi: 10.1177/0269215508101741.

8. Horn KK, Jennings S, Richardson G, van Vliet D, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. *J Orthop Sports Phys Ther.* 2012;42(1):30-D17. doi: 10.2519/jospt.2012.3727.
9. Åsenlöf P, Siljebäck K. The patient goal priority questionnaire is moderately reproducible in people with persistent musculoskeletal pain. *Phys Ther.* 2009;89(11):1226-34. doi: 10.2522/ptj.20090030.
10. Doig E, Fleming J, Cornwell PL, Kuipers P. Qualitative exploration of a client-centered, goal-directed approach to community-based occupational therapy for adults with traumatic brain injury. *Am J Occup Ther.* 2009;63(5):559-68. doi: 10.5014/ajot.63.5.559.
11. Young CA, Manmathan GP, Ward JC. Perceptions of goal setting in a neurological rehabilitation unit: a qualitative study of patients, carers and staff. *J Rehabil Med.* 2008;40(3):190-4. doi: 10.2340/16501977-0147.
12. Webb PM, Glueckauf RL. The effects of direct involvement in goal setting on rehabilitation outcome for persons with traumatic brain injuries. *Rehabil Psychol.* 1994;39(3):179. doi: 10.1037/h0080321.
13. Arnetz JE, Almin I, Bergström K, Franzen Y, Nilsson H. Active patient involvement in the establishment of physical therapy goals: effects on treatment outcome and quality of care. *Adv Physiother.* 2004;6(2):50-69. doi: 10.1080/14038190310017147.
14. Gagné DE, Hoppes S. The effects of collaborative goal-focused occupational therapy on self-care skills: a pilot study. *Am J Occup Ther.* 2003;57(2):215-9. doi: 10.5014/ajot.57.2.215.
15. Bassett SF, Petrie KJ. The effect of treatment goals on patient compliance with physiotherapy exercise programmes. *Physiotherapy.* 1999;85(3):130-7. doi: 10.1016/S0031-9406(05)65693-3.
16. Ostelo RWJG, de Vet HCW, Vlaeyen JW et al. Behavioral graded activity following first-time lumbar disc surgery: 1-Year Results of a Randomized Clinical Trial. *Spine.* 2003;28(16):1757-65. doi: 10.1097/01.BRS.0000083317.62258.E6.
17. Eysen IC, Steultjens MP, De Groot V, Steultjens EM, Knol DL, Polman CH, Dekker J. A cluster randomised controlled trial on the efficacy of client-centred occupational therapy in multiple sclerosis: good process, poor outcome. *Disabil Rehabil.* 2013;35(19):1636-46. doi: 10.3109/09638288.2012.748845.
18. Wilkins S, Pollock N, Rochon S, Law M. Implementing client-centred practice: why is it so difficult to do? *Can J Occup Ther.* 2011;68(2):70-9. doi: 10.1177/000841740106800203.
19. Mudge S, Stretton C, Kayes N. Are physiotherapists comfortable with person-centred practice? An autoethnographic insight. *Disabil Rehabil.* 2014;36(6):457-63. doi: 10.3109/09638288.2013.797515.
20. Litchfield R, MacDougall C. Professional issues for physiotherapists in family-centred and community-based settings. *Austr J Physiother.* 2002;48(2):105-12. doi: 10.1016/S0004-9514(14)60204-X
21. Hoffmann TC, Bennett S, Tomsett C, Del Mar C. Brief training of student clinicians in shared decision making: a single-blind randomized controlled trial. *J Gen Intern Med.* 2014;29(6):844-9. doi: 10.1007/s11606-014-2765-5.
22. Kuipers P, Carlson G, Bailey S, Sharma A. A preliminary exploration of goal-setting in community-based rehabilitation for people with brain impairment. *Brain Impairment.* 2004;5(1):30-41. doi: 10.1375/brim.5.1.30.35404.
23. Shaw WS, Woiszwilllo MJ, Krupat E. Further validation of the Patient-Practitioner Orientation Scale (PPOS) from recorded visits for back pain. *Patient Educ Counseling.* 2012;89(2):288-91. doi: 10.1016/j.pec.2012.07.017.
24. Dwamena F, Holmes-Rovner M, Gaulden CM, Jorgenson S, Sadigh G, Sikorskii A, Lewin S, Smith RC, Coffey J, Olomu A, Beasley M. Interventions for providers to promote a patient-centred approach in clinical consultations. *Cochrane Database System Rev.* 2012;12. doi: 10.1002/14651858.CD003267.pub2.
25. Dyke P, Buttigieg P, Blackmore A. M, Ghose A. Use of the Measure of Process of Care for families (MPOC-56) and service providers (MPOC-SP) to evaluate family centered services in a paediatric disability setting. *Child Care Health Dev.* 2006;32(2):167-76. doi: 10.1111/j.1365-2214.2006.00604.x.

Received: 15.09.16

Accepted: 20.12.16