HEARTS TOGETHER: Concordance and the Role of the Healthcare Provider

A Concept Analysis

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ABSTRACT
Healthcare is an ever-changing field of study. New terminology and colloquialisms are introduced in medical and nursing literature constantly. Concordance is now evident in the vernacular of healthcare literature. The origin, evolution, and use of the term concordance is reflective of patient-centered healthcare. Concordance embraces this ideal and promotes an equal partnership between patients and providers. The creation of concordance correlates to the interactions of patients and healthcare providers. The role and qualities of healthcare providers impact the degree to which concordance is achieved.

KEYWORDS: adherence, compliance, concordance, qualities of healthcare providers, role of the provider, communication skills, microsystem, micro-level factors in healthcare, patient-provider trust, motivational interviewing, health literacy, learning styles, cultural sensitivity, time management, Benner’s Novice to Expert Model, Erikson’s Eight Stages of Development, Artinian’s Intersystem Model

Evidence supports the concept that effectiveness and implementation of a patient’s prescribed therapeutic regimen correlates to the value of the patient and healthcare provider’s relationship (Schoenthaler, Montague, Manwell, Brown, Schwartz & Linzer, 2013; Scott & McClure, 2010). The intention of this concept analysis is to examine what concordance is, how it is used in clinical practice, and how healthcare providers contribute to creating concordance. The background, evolution, and definition of the concept of concordance will be explored. In addition, the fundamental qualities of healthcare providers that construct a supportive, high-value patient/provider relationship will be analyzed. Multiple theories of all disciplines are integrated and applied in this concept analysis. In this body of work, healthcare providers are referred to as the provider or providers. The provider or providers can denote those that practice as an Advanced Practice Registered Nurse, Physician Assistant, or Physician. The concept of concordance and the role of the healthcare provider were evaluated using the guidelines and steps of Walker and Avant’s method of concept analysis (McEwen & Wills, 2014).

Evolution of Concordance and Concept Selection
The terms “compliance,” “adherence,” and “concordance” are mistakenly used interchangeably in healthcare literature and among providers (Gardner, 2014; Flagg, 2010; Snowden & Marland, 2012). The progression of the above-mentioned terminology has been studied extensively.

Alkari and Zyga (2014) noted that two physicians, Drs. Sackett and Haynes, first defined the term “compliance” in relation to prescribed medical regimens in the late 1970s. “Compliance” was defined as “the extent to which the patient’s behavior (in terms of taking medications, following diets, or following lifestyle changes) coincides with medical advice” (as cited by Alkari & Zyga, 2014, p. 190). Sackett and Haynes’ definition of compliance was ill-received due to the assumed negative and autocratic nature of the definition (Alkari & Zyga, 2014, Feldmann, 2012.). Feldmann (2012) described the connotations of the term “compliance” as “paternalistic...” while Alkari and Zyga (2014) cited several authors who believed that Sackett and Haynes’ definition implied that the patient was “disobedient” (p. 181). Gardner (2014) stated that the term “compliance” is associated with “lack of patient autonomy” and limited patient involvement in decision-making (p. 97).

Due to the negative connotations of “compliance,” a shift in the language used to define the degree to which patients followed a recommended therapeutic regimen occurred in the 1990s (Gardner, 2014). The term “adherence” replaced “compliance” (Gardner, 2014). Several definitions of “adherence” are found in the healthcare community. Gardner (2014) quoted the World Health Organization Adherence Project when defining adherence. “Adherence” is “the extent which a person’s behavior (taking medications, following a diet, and/or executing lifestyle changes), corresponds with agreed recommendations from the health care provider” (as cited by Gardner, 2014, p. 98).

The term “concordance” has become evident in recent healthcare literature (Gardner, 2014). The European medical community has particularly used and defined the term “concordance” in recent years to describe their approach to that they call “medicine taking” (Gardner, 2014). The evolution in the aforementioned terminology represents the progression in healthcare and the shift to patient-centered care (Hobden, 2006a). Multiple articles explain the rationale for using concordance provides an ideal strategy for managing medications.

With its modern approach to healthcare, concordance prioritizes the health of patients and patient autonomy, and it supports positive relationships between providers and patients. Concordance was selected as a concept due to its distinctive, innovative nature and its potential to change how patients and providers view one another. With its modern approach to healthcare, concordance prioritizes the health of patients and patient autonomy, and it supports positive relationships between providers and patients. Although changes occur in healthcare daily, the concept and culture of concordance offers a timely standard to enhance patient care and promote wellness.

Aims of Analysis
Due to the vast number of factors that can challenge influence concordance, this concept analysis will concentrate on the qualities of providers that contribute to concordance. This concentration was selected to improve the relationships between patients and providers and to promote an outcome that is satisfactory to both. The culture of concordance promotes a positive relationship between patients and providers. Interactions between patients and providers construct the foundation of concordance. Bronfenbrenner’s Ecological Systems Model and Theory and micro-level factors in healthcare explain the importance of encouraging and supportive patient/provider interactions.

Overview of Bronfenbrenner’s Ecological Systems Model and Micro-level Factors
By integrating Bronfenbrenner’s Ecological Systems Model and the World Health Organizations (WHO) definition of micro-level factors, Berben, Dobbel, Engberg, Hill, and Geels (2012) described how micro-level factors impact the patient’s adherence to medication regimens (p. 630). Berben et al. (2012) proposed that influences from interactions within the patient’s various environments or systems affected their adherence to medications (p. 630). This association can also be applied to the concept of concordance, as the inter-
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Chee ... treatment options (Chee ... 2006). It is the responsibility of the provider to inform the patient of current and plausible treatment options (Chee ... 2006).

Value of the Patient/Provider Relationship

The final attribute of concordance is the value of the patient/provider relationship. Schoenholzer et al. (2014) found that the quality of the patient/physician relationship was imperative in detecting and treating hypenentia in underserved populations. A patient’s adherence to medications has been associated with fostering, trusting, and supportive relationships with their provider. (Berden et al., 2012; Snowden, 2012; Snowden & Marland 2012).

Proposed Theoretical Definition

After exploring the defining attributes of concordance, a new theoretical definition can be proposed. Concordance is an agreement between a patient and provider that is embodied by a mutual partnership through which the patient is empowered by their provider via the exchanging of knowledge about their particular health issue. A cohesive and congruent plan of care is created through shared decision-making, which is then implemented and maintained by continued correspondences between the patient and provider resulting in a high value patient-provider relationship.

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The value of the patient/provider relationship directly correlates to the successful realization of concordance and improvement in condition.

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Antecedents

The antecedents of concordance are focused solely on the provider. Per the implications of concordance, it was found that the quality of the patient/physician relationship was imperative in detecting and treating hypenentia in underserved populations. A patient’s adherence to medications has been associated with fostering, trusting, and supportive relationships with their provider. (Berden et al., 2012; Snowden, 2012; Snowden & Marland 2012).
Bronfenbrenner’s Model and Theory and the definition of micro-level factors in healthcare, interactions between the provider and patient influence the patient’s health behavior. Generating concordance is dependent on the provider, as he or she is the gatekeeper or facilitator to behavior. Generating concordance is dependent on the Bronfenbrenner’s Model and Theory and the definition of influence on concordance.

Establishment of Trust in the Provider

As previously mentioned, concordance assumes agreement between two parties. That being said, how does one achieve an agreement? Trust is a precondition for an agreement. Ultimately, concordance cannot occur if trust is not established between the provider and patient.

Trust is a basic human instinct that is established during infancy. Erik Erikson, a renowned psychoanalyst, developed an eight-stage model of psychosocial development (McEwen & Wills, 2014; Varcarolis, 2006). The first stage of this model is Trust vs. Mistrust. If a parent does not institute trust with an infant, the infant will withdraw (McEwen & Wills, 2014; Varcarolis, 2006). The child then lacks the ideals of trust, and the child may be unable to trust others in the future (McEwen & Wills, 2014; Varcarolis, 2006). Erikson’s theory can most definitely be applied to the patient/provider relationship. If a patient never fully developed the instinct of trust or had previous negative experiences with trusting others, the provider may never be able to enter a partnership with the patient.

The provider must be cognizant of a patient’s ability or inability to trust another person. Multiple articles state that a patient must have a high level of trust toward their provider to adhere to their medication regimen (Berben et al., 2013; Schoenthaler et al., 2013; Williams et al., 2016). Williams et al. (2016) found that provider trust was needed in order for patients to feel comfortable with the provider. When the patient feels comfortable with the provider, the patient was able to be truthful about their faithfulness to their prescribed medication regimen (Williams et al., 2013). These findings can be applied to the concept of concordance. The concept of concordance embraces the patient’s most innate instinct, that of trust. It is the duty of the provider to establish trust with patients. If trust is not established, not only will concordance be inhibited, but the overall health of a patient may be compromised.

Communication Skills of the Provider

Throughout the literature evaluated, the type of communication utilized and demonstrated by the provider was a significant factor in patient/provider trust, with a strong influence on concordance. Both nonverbal and verbal communication are imperative for establishing the patient’s trust in the provider and creating concordance.

Nonverbal communication. After studying the neurologic responses of patients during encounters with doctors, Benedetti (2011) concluded that facial expressions of doctors directly impact patients’ ability to trust doctors. The amygdala is activated when assessing if a person’s face is trustworthy (Benedetti, 2011). The activity level of the amygdala corresponds to degrees of trust (Benedetti, 2011). For example, if the activity level is low then the patient is likely to find the doctor trustworthy (Benedetti, 2011). In fact, eye contact, posture, and gestures communicate information as much as verbal communication and play an indispensable role in positive social interaction (Benedetti, 2011). Somatosensory input or tactile stimulation was also found to be an integral aspect of nonverbal communication because touch promoted social bonding between two people (Benedetti, 2011).

Verbal communication. Nonverbal communication in patient care is often accompanied by speaking. Effective verbal communication skills of the provider are key to conveying the importance of a diagnosis. Subtle differences in a provider’s speech and tone provoked varied positive or negative neurologic responses (Benedetti, 2011). This either strengthened or weakened the patient-provider relationship (Benedetti, 2011). Benedetti (2011) cited a study that found ‘certain’ statements (statements that were of sureness in nature) of the provider provoked a favorable outcome for the patient and promoted patient/provider trust.

Motiveational interviewing. Multiple references suggested the technique of motivational interviewing as a tool for providers to employ when interacting with and assessing patients (Berben et al., 2012; Hamric, Hanson, Tracy, & O’Grady, 2014; Hart, Bird, and Holloway, 2016). Motivational interviewing is aimed at evoking a change in patient behavior that results in a positive outcome (Hart et al., 2016). The provider should allow the patient to talk the majority of the time during their interaction by asking open-ended questions, which grants the provider insight into the patient’s true concerns (Hart et al., 2016). Providing the patient with opportunities to reflect on their own thoughts and impart affirmation in a respectful manner are also two aspects of motivational interviewing that are shown to increase a patient’s ability to change (Hamric et al., 2014; Hart et al., 2016).

Patient Contextualization

The provider may listen to a patient during their interaction, but is the provider really hearing what he or she is saying? The medical issues of a patient can be so complex that often the provider is unable to see the core of the patient’s real problem (Weiner & Schwartz, 2016). Weiner and Schwartz (2016) stated that doctors are often focused on diagnosing a rare condition, and in doing so they overlook simple information and insights to the patient’s problem. For example, a known diabetic patient repeatedly comes into an emergency room with blood glucose levels that range from 500-700. The provider treats the patient’s hyperglycemia but fails to ask why the patient has not been to their primary care provider (PCP) to adjust their insulin regimen. Perhaps, the patient works during the times that their PCP is open, or the patient lost his or her job and cannot afford the new prescription. By acknowledging a patient’s circumstances and going beyond the patient’s medical problem, the provider will achieve concordance and increase the value of their relationship.

Delivery of Patient Education

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One of the defining attributes of concordance is knowledge empowerment of patients. The education of patients is multidimensional and requires special attention of the provider. Each patient learns in unique ways. Providers must be aware of the many factors that affect the education of patients. The creation of concordance may be confounded if the provider is not conscientious to the individualized learning needs of each patient.

Language barriers. Berben et al. (2013) cited multiple studies that noted language barriers between patients and providers led to poor quality of care and unsatisfactory patient health outcomes. The implementation of language interpretation services at Mercy Medical Center in Des Moines, Iowa, improved patient outcomes in pediatric surgical patients (Weldon, Langan, Medema, Myers, Oakes, & Walker, 2014). An increase in overall satisfaction in care among the patient, patient’s family, and the healthcare team was also noted (Weldon et al., 2016). Providers should use language aids and interpreters.
Hamric et al. (2014) suggested that cultural sensitivity should have comprehensible explanations and be coherent in distributing handouts to the patient about medication or regimen when the information was concise and delivered likely to understand and adhere to their medication regimen. Kidney transplant patients were more likely to comply with medicines prescribed regimen and increased mortality. Each patient is from a different educational background, and the provider must be aware of this factor.

Learning styles also vary among patients. The provider must know how the patient prefers to learn. Patients may learn by listening, reading, viewing illustrated materials, demonstrations, or by a combination of the listed learning styles (Guse, Loesence, Stormer, Kuishoer, & Fei, 2012). The provider must be able to recognize the patients’ learning style and employ appropriate strategies when educating each and every patient in order to create and achieve concordance.

Timing of education. The timing of patient education should be appropriate to the patient’s condition. The provider must be aware of when and where to educate the patient. Williams et al. (2016) found that medication education about immunosuppressant regimens should be presented to kidney transplant patients prior to surgery. Information given to a kidney transplant patient after surgery was not effective and associated with low medication adherence (Williams et al., 2016). Williams et al. (2016) suggested limiting the amount of information presented to the patient and arranging multiple pre-surgery information sessions about immunsuppressant medications. Kidney transplant patients were more likely to understand and adhere to their medication regimen when the information was concise and delivered in an appropriate environment (Williams et al., 2016).

Clear and concise information. The provider may distribute handouts to the patient about medication or diets after deciding on a plan of care. This information should have comprehensible explanations and be coherent with what was discussed during the appointment (Hobden, 2006b). Conflicting information in handouts was found to confuse patients and created dissonance between the provider and patient (Hobden, 2006).

Cultural Sensitivity

Reverence to the practices of various cultures is necessary in healthcare to provide optimal care. Respecting a patient’s cultural practices and beliefs about healthcare strengthens the bond between the provider and patient (Hamric et al., 2014). Hamric et al. (2014) suggested that providers should evaluate his or her personal beliefs and cultural bias. By doing so, the provider can begin to overcome culturally insensitive attitudes and impart culturally competent care to further promote concordance (Hamric et al., 2014).

Time Management and Utilization

Time is a multifaceted antecedent of concordance. Several dimensions of time can be applied to this antecedent. Today’s providers have high patient volumes. It is absolutely necessary that providers manage and utilize their time with patients efficiently and effectively, as concordance only flourishes if sufficient time is spent with patients.

Length of time spent with patient. Cheesman (2006) stated that a greater amount of time spent with a patient in their first appointment with a new provider encourages concordance. Wilson and Childs (2002) found that providers were able to identify psychosocial problems when they spent more time with a patient. Increase in the amount of time spent with the patient also showed a decrease in unnecessary prescriptions and increased patient approval of the provider (Wilson and Childs, 2002).

Provider experience. Experience of the provider is directly correlated to time management skills. Konrad et al. (2010) stated more experienced providers had advanced clinical skills that enabled them to utilize time more efficiently. Time management and utilization is a skill that the provider must develop in order to not only be a well-organized provider but to also create concordance with all of their patients.

Follow-up appointments. Follow-up appointments with the same provider are essential to achieving concordance. Williams et al. (2016) found that use of different medical staff members often hindered the development of patient-provider partnerships and medication adherence. Consistency in providers creates rapport with the patient, which encourages concordance.

Fundamental Proficiency

The provider must have the appropriate education, licensure, and credentialing to practice as a healthcare provider in their state or country. This may vary from state to state or country to country. For example, an Advance Practice Registered Nurse must have graduated from an accredited masters level program, maintain his or her licensure and credentialing, and perform an adequate amount of competencies or continued education credits each year to remain in practice (Hamric et al., 2014).

Mastery of Practice

Patricia Benner’s Model of Skills Acquisition is applicable to this antecedent. Using Benner’s Novice to Expert Theory, the provider will navigate five stages as they gain expertise and experience (McEwen & Willis, 2014). The five stages mirror increased educational, advanced beginner, competent, proficient, and expert (McEwen & Willis, 2014). Throughout a provider’s career, according to Benner’s theory, he or she will gain the skills and knowledge to become an expert in their field (McEwen & Willis, 2014). Concordance, both the creation and maintenance of it, is very much dependent on the skills of providers. As previously noted, more experienced providers were able to utilize time more efficiently. One can assume using Benner’s Theory is this true for other skills, such as communication (McEwen & Willis, 2014).

Commitment to Professional Growth and Continued Education

In order to adapt to the constant changes in healthcare, the provider must be committed to developing his or her skills in accordance to current healthcare standards of practice. This can be done through joining professional organizations, completing educational contact hours, attending conferences, or obtaining one’s terminal degree (Beiden et al., 2012; Hamric et al., 2014). By learning new skills, such as better ways to communicate with patients and staying informed about current practice, the provider will be able to better educate and treat patients.

Awareness of Meso-level and Macro-level Factors

Providers must be aware of factors that are beyond the jurisdiction of both patients and providers, as these regulations may affect concordance. Meso-level and macro-level factors also heavily influence the patient’s behavior, health, and plan of care. The provider must acknowledge and act in accordance to these factors to further instill concordance.

Meso-level factors. Meso-level factors are the regulations and practice guidelines of the healthcare organizations in which a patient is treated, such as a clinic or a hospital (as cited by Beren et al., 2013). The guidelines in a clinic most definitely differ from the inner workings of a hospital and vice-versa. In order to comprehensively treat patients, the provider must be aware of the institutions set standards and limitations (Beren et al., 2013).

Macro-level factors. Macro-level factors are based in the healthcare system itself (as cited by Beren et al., 2013). This includes legislation, insurance coverage, and reimbursement (Beren et al., 2013). The provider must know what legislation may limit their practice, as this may affect patient negatively. The provider should also be familiar with various types of insurances, such as Medicare and Medicaid, which may have restrictions on certain medications and procedures.

Provider's Receptivity to the Culture of Concordance

Consequences

Consequences of concordance in the literature reviewed are rated in relation to patients successfully following their prescribed medication regimen, improving condition, and raising the value of the patient/provider relationship (as cited by Snowdon et al., 2013). Imogene King’s Theory of Goal Attainment is applicable to the consequences of concordance. Satisfaction between the patient and provider will occur if the goals of the plan of care are attained (McEwen & Willis, 2013). Hence, the consequences of concordance can also be based in the satisfaction of both the patient and provider.

The above consequences are positive, but negative consequences can also occur if the provider does not effectively create and nurture concordance. This may include: lack of trust in the provider, misuse of medications, missed treatment appointments, missed follow-up appointments, worsening of condition, new onset of preventable diseases, and lack of or dissatisfaction in the patient/provider relationship.
and what his goals are for his health. When Brian enters Rose decides to call him and discuss his hopes for the complaint is fatigue. Prior to officially meeting Brian, and the patient.

Rose is meeting a new patient today whose chief underlying medical condition causing this fatigue. and few other blood tests that will indicate if there is an and expertise, Rose suggests testing his vitamin D levels

Brian learns best by reading and writing and can understand both English and Spanish information at a high-school level. Rose provides English high-school level information about the importance of vitamin D and guidelines about adapting to nighttime work to Brian. Rose addresses Brian’s type of insurance and orders the blood tests in accordance to his insurance regulations. Rose also suggests taking vitamin D in addition to his multi-vitamin. Rose arranges another appointment to follow-up about his tests and regimen of vitamin D. Rose advises Brian to call her office with any issue at the end of the session. As Rose says this to Brian, she places her hand on his shoulder reassuringly.

Rose called the results of Brian’s test to him within 48 hours. In the follow-up visit, Brian states he is feeling less tired and has been following his regimen of vitamin D. Both Brian and Rose are satisfied with the outcome and continue to meet as needed.

Borderline Case
Tony has been practicing as a nurse practitioner for three years. He has yet to join any professional organizations but attends one conference a year. Tony is still transitioning into his role as an advanced care provider. Tony is meeting Daisy for the first time. Daisy is a middle-aged, single, Caucasian female with a history of depression. Tony is running about twenty minutes behind schedule. Despite being behind schedule, he feels prepared for the appointment because he spent some time reviewing Daisy’s chart yesterday. Today, Daisy wants to talk to Tony about changing her medication regimen for depression. Tony is somewhat apprehensive about prescribing her a new antidepressant, because Daisy admittedly does not normally take her medications as prescribed. She also often stops taking her medications abruptly. Tony knock’s prior to entering the room, smiles, and shakes her hand. After shaking her hand Tony sets up his computer, and there is silence behind the door. Daisy begins to get flustered, especially with the question of why she has not followed the previous prescription regimens. Tony realizes her frustrations and apologizes. He then asks Daisy if she has any financial troubles. Tony then discovers a key insight about the prescription, and Tony directs the medical assistant to take the call because he is behind schedule.

The medical assistant tries to answer her questions but is unsure of how to answer some of the specific questions about the medication. The medical assistant leaves Tony a reminder to call Daisy back. Tony neglects to call Daisy for one week. Daisy and Tony discuss her concerns and Daisy decides to fill the prescription and take the medication as directed. Tony tries to reassure her over the phone and encourages her to call back with any questions. Daisy is unsure if Tony will answer if she calls again. Daisy fills the prescription and decides she will go to the follow-up appointment only if the pills are not working.

Contrary case
Mark has been a nurse practitioner for seven years. Within this time, Mark has done the minimum to stay credentialed, does not attend conferences, and is not a member of any professional organizations. Mark believes that patients should listen and follow his recommenda-

Concordance cannot be classified as unsuccessful or successful or ineffective or effective. The essence of concordance is meant to go beyond measurable adherence and compliance to a medication regimen.
adherence and compliance to a medication regimen. Being concordant in two narrow categories like these limits the implications of concordance.

Flagg (2010) noted that very few reliable tools were available to test concordance before the Leeds Attitude Toward Concordance (LATcon) scale. The LATcon scale was first tested and widely used in the United Kingdom (Flagg, 2010). The purpose of the LATcon scale is to measure the attitudes of both patients and providers about their partnership and satisfaction, as well as the effectiveness of his or her selected medication regimen and treatment plan (Flagg, 2010). The goal is to quantify the degrees to which concordance was achieved and examine both points of view of patients and providers (Flagg, 2010).

Flagg (2010) used the LATcon scale as a guide and created a scale called the Revised United States-Leeds Attitude Toward Concordance (R-USLATcon) scale. Flagg (2010) changed certain phrases in the scale to make the R-USLATcon scale applicable to American providers and patients. Examples of a response statements on the R-USLATcon scale are: “During an outpatient visit, the lay, J.B. (2010). It's about time: Physicians' perceptions of strategies to promote concordance within consultations. British Journal of General Practice, 60(571), 667-672. doi:10.3399/bjgp10X609457.

This hearts together culture of concordance will create positive outcomes for patients and will lead to a very satisfactory, high-value patient/provider relationship.

In summary, concordance is a concept that transcends its predecessors of compliance and adherence and is a modern approach to patient-centered care. Concordance is developed and maintained by a unified partnership between a patient and his or her provider. The patient's interactions and experiences with his or her provider greatly impact their willingness to participate in a plan of care and change unhealthy behavior, as made evident by this concept analysis. This hearts together culture of concordance will create positive outcomes for patients and will lead to a very satisfactory, high-value patient/provider relationship.

Providers must be mindful of their influence and role in concordance. Much of the creation and maintenance of concordance is reliant on the qualities, skills, and beliefs of the provider. Although the responsibilities that accompany concordance may be daunting for the provider, he or she is ethically obligated as a healthcare professional to provide the highest quality and safest care to all patients.

Limitations

The provider and his or her role in concordance was the focus of this work. Additional factors that affect concordance should continue to be studied. Other studies could include the role of the healthcare system on concordance or the patient’s health literacy in relation to concordance. Concordance is a multi-faceted area of healthcare which must be examined from all aspects to fully grasp its magnitude and applicability.

REFERENCES


